STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675975	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Creek Rehabilitation and Nursing Center	705 N Main St Lumberton, TX 77657

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that alleged violations involving abuse were reported immediately to the Administrator of the facility for 1 of 7 residents (Resident #1) reviewed for reporting. The facility failed to ensure LVN A reported injury of unknown origin found on Resident #1 to the Administrator on 06/20/2025. This failure could place residents at risk for injuries of unknown origin not being reported.Findings included: Record review of Resident #1's face sheet, dated 10/20/2025, indicated Resident #1 was a [AGE] year-old male with an initial admission date of 03/30/2023 and re- admitted on [DATE]. Record review of Resident #1's Quarterly MDS, dated [DATE], reflected a BIMS score of 03 indicating severe cognitive impairment. His diagnoses included Type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar), seizure disorder (abnormal electrical activity in the brain leading to recurrent seizures.), autistic disorder (challenges in social communication and interaction, along with restricted and repetitive behaviors), cerebral palsy (a condition that affects movement and posture). In section B- (hearing, speech, vision) indicated Resident #1 was sometimes understood by others and at times could make himself understood to others. In section GG- (Functional abilities) indicated Resident #1 required setup assistance for chair to bed transfers and needed maximal assistance for dressing, and personal hygiene. Record review of Resident #1's nurses note, dated 6/20/2025 at 9:28 p.m., written by LVN A indicated, RP reported bruising to right upper arm. Healing bruise noted to right inner upper arm. Resident #1 unable to voice what happened. Will continue to monitor. Record review of grievance logs, dated 06/2025 and 07/2025, indicated there was no grievance report for Resident #1 regarding bruises underneath his right arm. Record review of incident reports, dated 06/2025 and 07/2025, indicated there was no incident report for Resident #1 regarding bruises underneath his right arm. During an interview and observation with Resident #1 on 10/30/2025 at 10:27 a.m., indicated Resident #1 was in his shared room with his dad playing with bedsheets. The surveyor attempted to have a conversation with Resident #1, he was unable to say his name, date, or how bruised he was. Resident #1 has a BIMS score of 03 indicating Resident #1 had severe cognitive impairment. During an interview and observation with Resident #1's RP, on 10/30/2025 at 10:30 a. m., indicated Resident #1 approximately had four half penny sized yellow-colored faded bruises underneath the upper part of his right arm (in the armpit region). He said he noticed the bruising under Resident #1's right arm in the armpit region on 06 /20/2025. Resident #1's RP said he did not know how the resident got the bruises and could not tell him what caused the bruises. Resident #1's RP said he immediately went to LVN A and reported the bruises. During an observation Resident #1's RP showed surveyor a picture of the faded bruising he found on Resident #1, with approximately four half penny sized yellow-colored faded bruises underneath the upper part of his right arm (in the armpit region). During an interview on 10/30/2025 at 11:15 a.m., the ADON said she had never received any reports from any staff member regarding Resident #1's bruising under his right arm. The ADON said she educated staff on reporting any marks or bruising of unknown origin. She said the Administrator should have been immediately contacted when the nurse received the bruising report from Resident #1's RP. She said the DON and ADON conducted in-services on when and how to report bruising of unknown origin. During an interview with LVN A on 10/30/2025 at 12:05 p. m. LVN A said Resident #1's RP reported to her Resident #1 had bruising to his right arm. LVN A said she assessed Resident #1 and saw he was not in distress nor acting outside of his normal behavior. LVN A said she asked Resident #1 how he was bruised. She said Resident #1 was unable to answer. LVN A said she made a nurse's note about the bruising. She said she did not report it to the ADON, DON, nor the Administrator because she did not know how the bruising occurred. LVN A said she had been trained on reporting bruises of unknown origin by the ADON. LVN A said she should have reported it to either the ADON, DON, or the Administrator immediately. She said not reporting potentially placed residents at risk for their bruises of unknown origin not getting investigated. An interview with the Administrator on 10/30/2025 at 12:46 p.m. indicated the Administrator said she was not made aware of bruising underneath Resident #1's right arm. She said Resident #1's RP did not report it to her. The administrator said it was her first time hearing Resident #1 had any kind of bruising. The Administrator said all staff had been in- serviced on reporting bruises of unknown origin. She said her expectation is for staff to report any kind of bruising of unknown origin immediately to her and the DON. The potential risk to the resident's if not done would be the facility would not be able to start an investigation. During an interview on 10/30/2025 at 12:50 p.m., the DON

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure in accordance with state and federal laws, all drugs and biologicals were stored in locked compartments and permitted only authorized personnel to have access to medication carts for 1 of 2 Nurse medication carts (Hall 100 Nurse Cart) reviewed for medication storage. LVN E failed to ensure the Hall 100 Nurse medication cart was kept locked and under direct observation where residents and unauthorized staff could not access it when left at the main nurse's station for six minutes.This failure could place residents at risk of unauthorized persons, as well as residents, at risk of gaining access to unlocked medications that were not prescribed to them.Findings included:Observation on 10/29/25 from 5:20 p.m. to 5:26 p.m., indicated the Hall 100 Nurse medication cart was noted to be unsecured and unsupervised at the main nurse station. The Hall 100 Nurse medication cart was front facing with the drawers facing the hallway with the lock mechanism out (indicating it was unlocked). At 5:27 p.m. the state surveyor notified LVN E, who was coming out of a closed door halfway down 100 hall and approximately 100 feet away from the unlocked 100 hall nurse medication cart. Further observation of 100 hall nurse cart with LVN E, indicated inside the medication cart Drawer #1 were accu-check strips and glucometers, OTC (over the counter) aspirin, vitamins, minerals and eye drops. Drawer #2 had a locked compartment with several controlled substances, and multiple resident's individual medication bubble-blister packets.During an interview on 10/29/25 at 5:30 p.m. LVN E said she was in charge of the cart. LVN E turned around, went to the cart and said she was sorry for leaving the cart open and she was the person responsible for administering medications on the 100 hall and used the cart. LVN E said she was in a room talking with a resident with the room door closed and the cart was out of her line of site. LVN E said she forgot to lock the cart before she stepped away from it. LVN E said the cart should not be unlocked and unattended because anyone walking by could get into the medications and risk medication theft or diversion. LVN E said she was in-serviced this year to keep the medication cart locked at all times when not in use. During an interview on 10/30/25 at 12:45 p.m., the DON said she expected the nurses to follow the facility values, policy and procedure related to medication pass and drug safety. She said the medication carts should be locked if staff walked away from it or turned their back to it. The DON stated she was responsible for making sure the nurses locked the carts because of risk for misappropriation of property. The DON said she made random rounds daily and checked to make sure nurses locked their medication carts. She said she had in-serviced nursing staff to keep the medication cart locked at all times. She stated nurses were trained during orientation, annually and as needed, on medication administration and securing meds.During an interview on 10/30/25 at 1:00 p.m., the Administrator said the expectation was that staff would follow medication safety policy and procedures to lock and secure the medication carts when not in use. She said all nursing staff were responsible for securing medications when not in use. She said the potential risk of unsecured medication cart was medication safety.Record review of the facility's Storage of Medication policy and procedure, dated 6/24/25, indicated , Policy Statement: The facility stores all drugs and biologicals in a safe, secure and orderly manner. Policy Interpretation and Implementation: 1. Drugs and biologicals used in the facility are stored in locked compartments.3. The nursing staff is responsible for maintaining storage and preparation areas.8. Compartments (including, but not limited to , drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biologicals are locked when not in use. 9. Unlocked medication carts are not left unattended. 12. Only persons authorized to prepare and administer medications have access to locked medications.