STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675977	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Creek Nursing & Rehabilitation	3825 Village Creek Rd Fort Worth, TX 76119

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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, interviews, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 5 residents (Resident #1) reviewed for quality of care.The facility failed to identify and treat swelling on Resident #1's cheekbone following a fall and after Hospice Nurse E and CNA B had identified it on 10/09/25. The failure placed residents at risk for delayed treatment. Findings included:Record review of Resident 1#'s annual MDS assessment, dated 09/13/25, reflected the resident was a [AGE] year-old female, who was admitted to the facility on [DATE]. The resident's diagnoses included metabolic encephalopathy, non-Alzheimer's Dementia (brain disorder caused by damage to nerve cells in the brain), anxiety disorder (a mood disorder characterized by excessive, persistent, and uncontrollable fear and worry about everyday situations), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), bipolar disorder, schizophrenia and diabetes mellitus (a chronic disease characterized by high level of sugar in the blood). The MDS reflected Resident #1 had severe cognitive impairment with a BIMS score of 5.Record review of Resident #1's care plan, revised date 10/12/25, reflected: Focus: Falls: (Resident #1) is at risk to fall r/t DX: Metabolic encephalopathy, dementia w/decreased cognition, hx UTI, hx Pneumonia, DM II, anxiety, depression, chronic pin syndrome, bipolar disorder, schizoid personality disorder, malnutrition, toxic nephropathy, insomnia, contractures to bilateral ankles, decreased mobility & self-function, incontinence, medical Noncompliance including refusal of medications and resistive to ADL care. fall #1 of 10/9/2025, fall #2 of 10/9/2025. (Resident #1) has attention seeking behaviors of putting herself on the floor or intentionally rolling herself out of bed causing no injuries. Goal: (Resident #1) will be free of falls through the review date. Interventions: Hospice evaluation of patient condition and medication adjustment 10/09/25. Send out to Texas Health [NAME] for evaluation and treatment 10/9/2025. Monitor left facial swelling with abrasion and blanchable redness to left arm 10/10/2025. Add full bed mattress on floor with sheet next to bed to act as secondary level of protection for [Resident #1] when behavior seeking and attempting to get out of bed without assistance. Be sure [Resident #1] call light is within reach and encourage her to use it for assistance as needed. Encourage [NAME] to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Focus: [Resident #1] has attention seeking behaviors of putting herself on the floor or intentionally rolling herself out of bed causing no injuries. Goals: Review [Resident #1's] behaviors when they arise for possible options for adjusting to the current situation over the next 90 days. [Resident #1] will demonstrate less demanding behavior towards others over the next 90 days. Record review of Resident #1's Weekly Skin Check, dated 10/09/25 at 10:00 AM, reflected no skin impairments. Record review of Resident #1's progress note, dated 10/09/25 at 10:00 by LVN A reflected: Late Entry: Note Text: Patient noted on the full mattress next to bedside shortly after administration of ABH gel and pain medication, resident assessed, Neuro check initiated, no changes noted during assessment, no complain of pain or discomfort, CNA assigned assisted to bed to provide incontinent care and transfer to W/C and taking to nurses station to close monitor and continue Neuro check, resident was taken to activities for continued supervision. Record review of Resident #1's Fall with Injury assessment dated [DATE] at 10:00 AM reflected, Incident location: Resident's room. Incident Description: Resident found on her left side of on mattress by LVN charge nurse. Resident unable to give description. Immediate Action Taken: LVN charge nurse assessed resident. Resident assisted back into bed by LVN charge nurse and CNA. Hospice in facility for visit. Injuries Observed at time of incident Injury Type: No injuries observed at time of incident. Injuries Reported Post Incident: No injuries observed post incident. Other Info: resident has hx of combative behavior, attempting to transfer self out of bed and covering face with blanket, resistant to care. People notified [Family Member A, Hospice Nurse E and Hospice MD]. Record review of Resident #1's Neurological Assessment Flow Sheet dated 10/09/25 from 10:00 AM to 9:45 PM] reflected no there were no concerns regarding Resident #1's level of consciousness, pupil response, motor functions, pain response, or vitals. Record review of Resident #1's Hospice Nurse Recertification notes documented by Hospice Nurse E for her visit with Resident #1 on 10/09/25 at 11:50 AM until 2:34 PM reflected: Integumentary [Skin] Status - New skin impairment(s) during past 60/90/180 days. Patient Wound: #1, Location: Periorbital swelling to left eye. Patient was placed in front of main nursing station by [LVN A]. Requested facility staff to transfer patient to bed so 'I' could observe her transfer with