STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676244	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Creek Lodge	11830 Northpointe Boulevard Tomball, TX 77377

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 7 (Resident #1 and #2) residents reviewed for comprehensive assessments. The facility failed to develop and implement a care plan (dated 07/01/2025) that addressed Resident #1’s new diagnosis of chronic kidney disease after return from hospital on [DATE]. The facility failed to develop and implement a care plan (dated 07/02/2025) that addressed Resident #2’s allergy to lactose and a fall with injury on 06/02/2025. This deficient practice could place residents at risk of not receiving interventions individualized to their health care needs. The findings included: Record review of Resident #1's face sheet, dated 01/01/2025, reflected a [AGE] year-old admitted to the facility on [DATE] and initially admitted on [DATE]. Resident #1 had diagnoses which included: Chronic kidney disease, stage 4 (severe, damage to the kidneys occur when the kidneys are unable to filter waste products from the blood. This is the last stage before kidney failure), disorder of kidney and ureter, cognitive communication deficit, dementia, diabetes, hypertension (elevated blood pressures), muscle wasting and Alzheimer’s disease. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 8 out of 15 indicating moderate impaired cognition. Resident #1 was always incontinent of bowel and bladder. The active diagnoses section included disorder of kidney and ureter. Record review of Resident #1’s hospital records, under the Nephrology Progress Notes, with the date of service as 06/10/2025 revealed an assessment to include CKD stage 3. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1’s hospital discharge summary notes with the admit date of 06/03/2025 and discharge date of 06/12/2025 revealed AKI (acute kidney injury) on CKD stage 4 (meaning AKI occurs in CKD patients and is known to be more severe and difficult to recover). Record review of Resident #1’s care plan printed on 07/01/2025 revealed CKD was not addressed; no goals or interventions were put into place on the care plan. Record review of Resident #1’s active physician orders as of 07/01/2025 revealed an order for Furosemide 40mg tablet by mouth daily for diuretic (a drug that promotes the increased production of urine), start date was 06/13/2025. Record review of Resident #2’s face sheet dated 07/02/2025 reflected an [AGE] year-old admitted to the facility on [DATE]. Resident #2 had an allergy to Lactose. Resident #2’s diagnoses included Hemiplegia (severe loss of strength on one side of the body), Aphasia (language disorder caused by damage in a specific area of the brain), GERD Gastroesophageal Reflux Disease (a condition where stomach acid flows back into the throat causing symptoms like heartburn), obesity, Dysphagia (swallowing disorder); Dysarthria and Anarthria (speech disorders caused by brain damage). Record review of Resident #2's quarterly MDS, dated [DATE], revealed she had short term and long-term memory problems. Resident #2 made consistent independent decisions regarding tasks of daily life and had no evidence of acute changes in mental status. Further review revealed the resident had no fall history. Record review of Resident #2’s active physician order for food allergies dated 6/20/2024 revealed she had a mild intolerance to lactose. Record review of Resident #2’s active physician orders as of 07/02/2025 revealed an order for regular diet, mechanical soft texture and thin consistency. Further review revealed dietary supplement orders for health shake daily with lunch r/t weight trend, start date was 06/26/2025. Continued review revealed no orders for lactase (an enzyme that breaks down lactose, preventing symptoms like gas, bloating and diarrhea associated with lactose intolerance). Record review of Resident #2’s change in condition evaluation dated 06/02/2025 revealed the resident had a fall and had a wound to the side of the right thigh and contusion to the right side of the head. Record review of Resident #2’s incident note dated 06/02/2025 at 8:55 PM, the resident had an unwitnessed fall and was found on the floor next to the bed. Further review revealed the physician was notified and the resident was sent to hospital for further evaluation. Record review of Resident #2’s nurse note dated 06/03/2025 at 1:50 AM, the resident returned from the hospital, alert and oriented and had no complaints. Record review of Resident #2’s care plan printed on 07/02/2025 revealed the allergy to lactose was not addressed. No goals and interventions were in place to prevent risk of complications. Further review revealed the fall that took place on 6/2/2025 was not addressed in the care plan. No goals or interventions were in place on the care plan to prevent injuries from falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 07/02/2025 at 2:00 PM revealed, Resident #2 was in the tv room sitting in a wheelchair that had a special large arm rest for her left arm. Resident #2 stated she recalled the fall, and she fell because she was practicing rolling from side to side in bed for when they clean her up. Resident #2 stated she hit her forehead on the wheel of the rolling table and hit her right cheek on the bar of the rolling table. She stated she had a bruise on the side of her face and had also hit her right thigh on the bar of the table. She stated it happened at night and she was sent to the hospital. She stated they did a CT scan, and nothing was broken. She stated that she had not fallen since then and that the nursing staff did remind her about safety. She stated she was lactose intolerant, and the kitchen knew but they keep sending her dairy products. She stated she can take lactase herself and it helped with preventing upset stomach. In an interview on 7/02/2025 at 3:00 PM, the MDS nurse who stated the purpose of the care plan was to meet with the IDT (interdisciplinary team), to educate staff and family members on the resident specific plan of care. The MDS nurse stated the care plan was based on resident needs, any changes in the resident’s status, significant change of condition, falls and behaviors. The MDS nurse stated if a resident had a fall, it would be discussed in the IDT meeting, added to the care plan because it must be represented in the care plan. The MDS nurse stated the team would place certain interventions to the care plan to help prevent injury or serious injury from occurring. The MDS nurse stated Resident #2’s fall was discussed on 06/03/2025 during risk management meeting and addressing it in the care plan was missed. The MDS nurse said she was responsible, and that not adding the fall to the care plan was an oversight. The MDS nurse stated Resident #2’s intolerance to lactose should be in the care plan was not and that it was also an oversight. The MDS nurse stated moving forward she would conduct chart audits so not to miss anything. The MDS nurse stated Resident #1’s CKD diagnosis should be in the care plan. The MDS nurse stated generally the admitting nurse and was responsible for adding information into PCC when a resident was admitted or readmitted and the information would be auto added to the 24-hour report. The MDS nurse stated during morning meetings, residents who were readmitted would be discussed including the rationale for readmission. The MDS nurse was asked how this could affect Resident #1 if CKD was not in the care plan: the MDS nurse stated the resident could be affected if there were any ongoing orders related to CKD that were not transferred over from the hospital. In an interview on 7/02/2025 at 4:16 PM, the DON who stated the purpose of the care plan was to provide a plan on how the resident will be cared for and modified to that specific resident. The DON stated if a resident had an active, new diagnosis that it would be addressed in the care plan. The DON stated Resident #1 was being followed by a kidney specialist therefore the CKD should be in the care plan. The DON stated she did not know why it was not added to the care plan. The DON stated allergies should also be addressed in the care plan and when Resident #2 had a fall, it was discussed during meetings and should have been added to the care plan as well. The DON stated with the fall not being addressed in the care plan we would not be able to implement interventions to prevent injury from falls. The DON stated it should have been added upon Resident #2’s return from the hospital on [DATE].). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled Care Plans, Comprehensive Person-Centered, revised on March 2022, read in part: “…A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident’s physical, psychosocial and functional needs is developed and implemented for each resident….3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment…11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents’ condition change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident’s condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay…” Record review of the undated facility policy and procedure titled Condition Change of the Resident read in part: “…Basic Responsibility: licensed nurse, other…Purpose: Observe record and report any condition change to the physician so proper treatment can be implemented…Care Plan Documentation Guidelines: 1. Identify underlying problem causing the condition change. 2. Record measurable goal for resolution of the condition. 3. Develop a plan to treat the condition. Observe and monitor resident’s response to treatment. Record preventative measures, safety measures and resident education provided…” Record review of the facility’s policy titled Falls and Fall Risk, Managing, revised March 2018, read in part: “Based on previous evaluations and current data, the staff will identify interventions related to the resident’s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling…1. The staff will monitor and document each resident’s response to interventions intended to reduce falling or the risks of falling…”