

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Willow Creek Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>(continued on next page)</p>

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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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview, and record review, the facility failed to ensure that the daily staffing was posted and readily accessible for review for 1 of 1 facility reviewed for required postings. On 11/12/25, the facility failed to ensure the Direct Care Daily Staffing Numbers were posted. This failure could affect residents, facility visitors, vendors, and emergency personnel by placing them at risk of not having access to information regarding daily nursing staffing in a timely manner. Findings Include: An observation on 11/19/25 at 07:40 AM revealed, there was no posting of the facility Direct Care Staffing Numbers. The placard that held the posting at the front entrance was empty. An observation on 11/19/25 at 08:15 AM revealed, there was no posting of the facility Direct Care Staffing Numbers. The placard that held the posting at the front entrance was empty. In an interview on 11/19/25 at 11:52 AM, the Staffing Coordinator said he took over the position recently and he was still in training. He said while he was responsible for ensuring the facility was adequately staffed, he was not responsible for the daily direct care posting. The Staffing Coordinator said he was never trained to complete the posting. He stated the DON normally posted them at the front entrance, and he did not know who was responsible for the posting in her absence. In an interview on 11/19/25 at 11:57 AM, the Administrator said he did not know the regulations surrounding the nursing posting, and it was the responsibility of the DON. He said he did not know why the posting was not completed today when the surveyor entered the building. He stated the DON was on leave since Monday, 11/17/25, and he did not know if the posting had or had not been updated since her leave began. He said, to his understanding, the posting must be up daily, but he did not know when. The Administrator said the posting served to notify consumers of the staffing level in the building, and failure to update the posting would leave them unaware of the facility staffing if they did not ask staff for it. He said the facility had multiple shifts with 12-hour shifts (6-6) for nurses and 8 hour shifts (6 AM- 2 PM, 2PM- 10PM and 10 PM- 6 AM) for CNAs/CMAs. In an interview on 11/19/25 at 01:53 PM, the ADON said the Staffing Coordinator was supposed to be responsible for the direct care posting, but he was new, so the DON had completed the task while he was training. She said the DON went out on leave on Monday, 11/17/25, so she completed the task in her place. The ADON said today, she asked the Staffing Coordinator to update posting, but she was not aware that he had not been trained on the task yet, so it was not completed. She said the posting's purpose was to inform visitors of the available staff types and hours, and it included the facility name, date, census, the staff types and total hours worked. The ADON said failure to have a direct care staff posting could result in visitors being unaware of the facility census, as well as the type and number of staff available in the building. In an interview on 11/19/25 at 01:58 PM, the Administrator said the facility did not have a specific policy on Posting Direct Care Daily Staffing Numbers. In an interview on 11/19/25 at 02:48 PM, the ADON said she had updated the Direct Care Daily Staffing Numbers posting daily since the DON went on leave, and she usually arrived at the facility between 07:45 AM and 08:00 AM. Record review of the facility's policy Staffing, Sufficient and Competent Nursing revised August 2022 revealed, 6. Direct care daily staffing numbers (the number of personnel responsible for provide direct care to residents) are posted in the facility for every shift by 10 am daily. Related Documents Posting Direct Care Daily Staffing Numbers.</p>		