

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 06/13/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48559</p> <p>Based on observation, interview, and record review, the facility failed to develop the comprehensive person-centered care plan with services furnished to maintain the resident's highest practicable physical well-being for 1 of 5 residents, (Resident #71), in that:</p> <ul style="list-style-type: none"> -The facility failed to ensure Resident #71's care plan was not updated to reflect the resident's need for a urinary catheter care. -This failure placed residents at risk of not receiving adequate care. <p>Findings Include:</p> <p>Record review of Resident #71 face sheet, dated 06/11/2024, reflected a [AGE] year old male admitted to the facility on [DATE] with diagnosis of infection and inflammatory reaction due to indwelling urethral catheter.</p> <p>Record review of Resident #71 Minimum Data Set (MDS) dated [DATE] reflected BIMS score of 04, which indicated severe impaired cognition.</p> <p>Record review of Resident #71 comprehensive care plan dated 05/25/2024 revealed no plan of care for urethral catheter care.</p> <p>Observed Resident #71 on 06/11/2024 lying in bed with head of bed at approximately 30 , urinary catheter noted with light yellow urine.</p> <p>In an interview with CNA A on 06/13/20/24 at 3:38 PM, CNA A stated nurses start care plans when the resident arrives to facility. All the care residents needs should be in the care plan., CNA A stated she is able to see planned for resident in the Plan of care (POC) tab in Point Click Care (PCC) (an electronic charting application). CNA A stated the reason for care plans is so everybody is knowledgeable of care that is needed by the resident and what to monitor for and report up the chain of command. She states the care plan is updated daily in the morning meeting. CNA A stated the risk of not having a care plan is the resident won't get the care they need and a possible lawsuit may occur.</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
---	-------	-----------

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 06/13/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with RN A on 06/13/2024 at 3:53 PM, RN A stated when the resident is admitted to the facility the nurse starts the baseline care plan in Point Click Care (PCC) (an electronic charting application). RN A stated safety, nutrition, activities of daily living, disease process should be in the care plan so the resident can get proper care. RN A stated the care plan is updated during daily rounds and as changes are noted during the shift. RN A stated information from the care plan is given to the CNA verbally and also through the plan of care tab in PCC. RN A stated the risk of not having a care plan is resident won't get proper care and is at risk for harm.</p> <p>In an interview with CNA B 6/13/2024 at 4:10 PM, CNA B stated nurses start the care plan when the resident arrives to facility. CNA B stated all residents' needs like mobility, and diet, should be in the care plan., stated she is able to see the plan in the Plan of care (POC) tab in Point Click Care (PCC). CNA B stated the reason for care plans is so everybody is knowledgeable of care that is needed by the resident and what to monitor for and report up the chain of command. She states the care plan is updated daily in the morning meeting either by the nurse or social worker. CNA B stated the risk of not having a care plan is the resident won't get the care they need and a possible harm to resident may occur.</p> <p>In an interview with LVN A on 6/13/2024 at 4:19 PM LVN A stated when the resident is admitted to the facility, the nurse starts the baseline care plan in Point Click Care (PCC) (an electronic charting application). LVN A stated safety, nutrition, mobility, activities of daily living, disease process should be in the care plan so the resident can get proper care. LVN A stated the care plan is updated during daily rounds and as changes are noted during the shift. LVN A stated, information from the care plan is given to the CNA verbally and also through the plan of care tab in PCC. LVN A stated the risk of not having a care plan is resident won't get proper care and is at risk for harm.</p> <p>In an interview with the DON on 6/13/2024 at 4:32 PM, the DON stated when the resident is admitted to the facility the admitting nurse begins the baseline care plan in Point Click Care (PCC). DON stated all diagnosis, mobility status, medications and treatments should be in the care plan so the resident can get proper care. DON stated the care plan is updated during Interdisciplinary Team meetings (IDT), daily rounds and as changes are noted during the shift, information from the care plan is given to the CNA verbally and also through the plan of care tab in PCC. DON stated the risk of not having a care plan is a failure to care for the resident, resident won't get proper care and is at risk for harm.</p> <p>In an interview with the Administrator on 6/13/20/24 at 4:43 PM, the Administrator stated when the resident is admitted to the facility, the admitting nurse begins the baseline care plan in Point Click Care (PCC). Administrator stated all of the residents needs should be in the care plan so the resident can get proper care. Administrator stated the care plan is updated by nurses as changes are noted during the shift. Administrator stated the risk of not having a care plan is unacceptable and is a potential failure to care for the resident, and resident is at risk for harm.</p> <p>(continued on next page)</p>		

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 06/13/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facilities policy titled, Care Plans, Comprehensive Person-Centered 2001 Med-Pass, Inc. (Revised July 2016) read in part . A comprehensive, person-centered care plan should include measurable objectives and timetables to meet the psychosocial and functional needs The comprehensive person-centered care plan should be developed within 7 days of the completion of the required MDS assessment and should be completed within 21 days of admission describe the services that are to be furnished in an attempt to assist the resident attain or maintain that level of physical, mental and psychosocial wellbeing that the resident desires or that is possible .interventions should address the underlying sources of the problem.</p>		

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 06/13/2024
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 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48559</p> <p>Based on observation, interview, and record review, the facility failed to ensure a physician supervised the care of a resident for one (Resident #71) of five residents reviewed for physician services in that:</p> <p>The facility failed to ensure the physician supervised and monitored Resident #71's indwelling urethral catheter since Resident #71 was diagnosed with infection and inflammatory reaction due to indwelling urethral catheter.</p> <p>This failure could cause a delay in appropriate medical care and a worsening in symptoms, condition, or illness up to and including death.</p> <p>Findings included:</p> <p>Record review of Resident #71's face sheet, dated 06/11/2024, reflected a 85 -year -old male admitted to the facility on [DATE] with diagnosis of Infection and inflammatory reaction due to indwelling urethral catheter.</p> <p>Record review of Resident #71's Minimum Data Set (MDS) dated [DATE] reflected BIMS score of 04, which indicated severe impaired cognition.</p> <p>Record review Resident #71's physician orders indicated Resident #71 didoes not have any orders from the physician to care for indwelling urethral catheter.</p> <p>Observed Resident #71 on 06/11/2024 lying in bed with head of bed at approximately 30 , urinary catheter noted with light yellow urine.</p> <p>In an interview with CNA A on 06/13/20/24 at 3:30 PM, CNA A stated that she did not review MD orders and gets her instruction for care from the nurse that observes the physician orders. CNA A stated she doesn't look for the orders but knows they are in Point Click Care (PCC) (an electronic charting application). CNA A stated MD orders are needed because of chain of command., they know what is best for the resident and she must not do any care that is not ordered by MD. CNA A stated the risk of not having a doctor or nurse practitioner order is that the wrong care could be given and a lawsuit might occur.</p> <p>In an interview with RN A on 06/13/2024 at 3:46 PM, RN A stated physician orders should be reviewed before performing care with a resident and before informing the CNA of care needed. MD orders are found in Point Click Care (PCC) under the order tab. Nurses give verbal instructions to CNA's for the care needed from the MD orders. RN A stated orders come from physician, hospital orders, and hospital orders will be verified with the primary care doctor during initial admit process. RN A stated if there are no orders for a particular treatment, one must call that doctor and have a discussion about what is needed. Physician orders are needed because nurses are not allowed to prescribe and the doctor is higher in the chain of command and is knowledgeable about resident needs. RN #1 stated the risk of not having MD orders is possible harm to resident and/or lawsuit can occur.</p> <p>(continued on next page)</p>		

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 06/13/2024
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 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with CNA B 6/13/2024 at 4:02 PM CNA B stated that she did not review MD orders and gets her instruction for care from the nurse that observes the physician orders. CNA B stated she doesn't look for the orders but knows they are in Point Click Care (PCC). CNA B stated MD orders are needed to be able to perform care for the resident. CNA B stated the risk of not having a doctor order is no care or wrong care could be given to resident with harmful effects and a lawsuit might occur.</p> <p>In an interview with LVN A on 6/13/2024 at 4:11 PM LVN A stated physician orders should be reviewed when seeing resident for the first time, before performing care and when informing the CNA of care needed. MD orders are found in Point Click Care (PCC) under the order tab. Nurses give verbal instructions to CNA's for the care needed from the MD orders. LVN A stated if there are no orders for a particular treatment one must call that doctor and ask for orders. Physician orders are needed for safety of resident, continuity of care. LVN#1 stated the risk of not having MD orders is possible harm to resident.</p> <p>In an interview with the DON on 6/13/2024 at 4:24 PM, the DON stated physician orders should be reviewed daily before performing care and before informing the CNA of care needed. MD orders are found in Point Click Care (PCC) under the order tab. Nurses give verbal instructions to CNA's for the care needed from the MD orders. DON stated if there are no orders for a particular treatment one must call that doctor and request orders. Physician orders are needed because nurses are not allowed to prescribe. DON stated the risk of not having MD orders is possible harm to resident. DON stated the expectation going forward is all residents will have orders for all treatments and she will begin a review process to identify any residents without proper orders regarding care.</p> <p>In an interview with the Administrator on 6/13/2024 at 4:36 PM, Administrator stated physician orders should be reviewed quickly. MD orders are found in Point Click Care (PCC) under the order tab. Administrator stated if there are no orders for a particular treatment the nurse should call that doctor and request orders. Physician orders are needed because they have a medical degree and that is how we operate. Administrator stated the risk of not having MD orders is not acceptable and possible harm could occur to resident. Administrator stated the expectation going forward is all residents will have orders for all treatments, and he will follow up with DON and ensure all residents have orders for treatments.</p> <p>Record review of facility's policy titled Medication and Treatment Orders, 2001 Med-Pass, Inc. (Revised July 2016) read in part Policy Statement Orders for medications and treatments will be consistent with principle of safe and effective order writing.</p>		

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 06/13/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48559</p> <p>Based on observation, interview, and record review, the facility failed to maintain correct chemical concentration, based on periodic testing, at least once per shift during the dishwasher's wash cycle in one of one kitchen.</p> <p>The facility failed to test and maintain proper concentration level of sanitizer solution during the dishwasher's wash cycle.</p> <p>This failure could affect all residents by placing them at risk for food-borne illness.</p> <p>Findings included:</p> <p>Observation of the kitchen on 06/11/2024 at 9:08 am revealed the facility's only dishwasher in use at the time, was a low-temp dishwasher. Staff A was observed performing a strip test after a load of dishes had been washed. The strip did not change color after 5 attempts; indicating lower than minimum PPM levels of sanitizer solution.</p> <p>Interview on 06/11/24 at 9:20 am with Staff A, the Dietary Supervisor revealed she arrived to work after her morning kitchen staff who was responsible of logging test results each morning, which she then verified. When asked about the entry for that morning and the two mornings prior, she stated she made staff aware of the logging requirement but did not ask staff to perform the test. She also stated she did not perform random strip tests herself and relied solely on what is logged by her staff. When asked what the risks were when there was a malfunction in the dishwasher, she stated the residents would be at risk for cross-contamination and diseases.</p> <p>Interview on 6/11/24 at 9:31 am with Staff B revealed he did not log testing results prior to the observation because he was in a hurry that morning and did not test sanitation levels during the wash.</p> <p>Interview on 6/13/24 at 3:10 pm with the Administrator revealed he was unaware of the dishwasher's malfunction. He stated he was made aware after the observation made by surveyor on 06/11/2024 and was also made aware of the repairs that occurred the next later that afternoon. He confirmed the facility's policy required kitchen staff to log concentration levels of sanitizing solution with the use of testing trips each shift during wash cycles.</p>