| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676304 | A. Building<br>B. Wing | 12/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Creekside Village | 914 N Brazosport Blvd<br>Richwood, TX 77531 |

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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide personal privacy when providing personal care for 1 (Resident #1) of 5 residents observed for personal care. -CNA A failed to provide privacy for Resident #1during incontinent care This failure placed residents at risk for their loss of dignity, respect, and psychological distress. Findings:Record review of Resident #1's face sheet dated 09/06/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and again on 05/08/24. Resident diagnoses included age related cataract, overactive bladder, hemiplegia (complete paralysis or loss of strength on one side of the body) and hemiparesis (partial weakness or loss of muscle strength on one side of the body) following cerebral infarction (when blood flow to the brain is disrupted), epilepsy (when nerve cell activity in the brain is disrupted, causing seizures), and anxiety (continuous worry, fear, and nervousness that can interfere with daily life). Record review of Resident #1's MDS dated [DATE] reflected a BIMS score of 15 indicating that resident cognition was intact.[JM1] Record review of Resident #1's Comprehensive Care Plan dated 05/16/24 and revised 08/01/25 revealed that resident was being care planned for bladder incontinence. Observation of incontinent care for Resident #1 on 09/26/25 at 11:30AM by CNA A. CNA A entered Resident #1's room and proceeded to transfer Resident #1 from her wheelchair to her bed. Resident #1's roommate was sitting in a chair on the left side of Resident #1's bed in a recliner chair. CNA A did not pull Resident #1's privacy curtains. CNA A proceeded to remove Resident #1's pants that were soiled in urine. Resident #1's brief was heavily soiled in urine. After cleaning resident, CNA A then placed a clean brief on resident along with clean pants. Interview on 09/26/25 at 11:45AM, CNA A said she worked at the facility full time for over 2 years. CNA A said she worked the 6AM-6PM shift. CNA A said she should have pulled Resident #1's privacy curtains when providing care for Resident #1. CNA A said she was nervous and therefore made a mistake.Interview on 09/26/25 at 12:45PM, the DON said whenever a resident is administered care including incontinent care they should be provided privacy by pulling the privacy curtains due to most of the residents having roommates. The DON said by doing this, it not only promotes resident dignity, but it also promotes a sense of security. Interview on 09/30/25 at 11:30AM, Resident #1 said when she was being provided with incontinent care, she preferred that the staff pulled her curtain for her privacy. Resident #1 said it was important to pull her privacy curtain because she never knew when someone might come into the room leaving her exposed. Resident #1 said if this happened, she would be embarrassed. Record review of the Nursing facility policy on Resident Rights dated February 2021 reflected in part: . Employees shall treat all residents with kindness, respect, and dignity. |

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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide resident with care and services for 1 (Resident #1) of 5 residents reviewed for activities of daily living care, in that: CNA B failed to check Resident #1 for incontinence and provided incontinent care every 2-3 hours. CNA A failed to thoroughly clean Resident #1 during incontinent care when resident pants were soiled and brief was heavily soiled in urine. This failure placed resident at risk for not being provided the care and services needed. Findings: Record review of Resident #1's face sheet dated 09/06/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and again on 05/08/24. Resident diagnoses included age related cataract, overactive bladder, hemiplegia (complete paralysis or loss of strength on one side of the body) and hemiparesis (partial weakness or loss of muscle strength on one side of the body) following cerebral infarction (when blood flow to the brain is disrupted), epilepsy (when nerve cell activity in the brain is disrupted, causing seizures), and anxiety (continuous worry, fear, and nervousness that can interfere with daily life). Record review of Resident #1's MDS dated [DATE] reflected a BIMS score of 15 indicating that resident cognition was intact. Further review section GG Functional abilities reflected that resident was dependent on toileting hygiene and required partial to moderate assistance with personal hygiene. Further review section H-Bladder and Bowel reflected that Resident #1 was always incontinent with urine and frequently incontinent of bowel. Record review of Resident #1's Comprehensive Care Plan dated 05/16/24 and revised 08/01/25 revealed that resident was being care planned for bladder incontinence with an intervention to check and change resident every 2-3 hours and PRN. Further review of interventions included wash, rinse, and dry resident perineum (the area of the skin and underlying tissue located between the anus {where stool exits the body}) and the vulva (area outside of a female genital area located at the entrance of the vagina). Observation on 09/26/25 at 11:28AM of Resident #1 sitting in wheelchair by the nurse station telling the staff she needed to be changed. Observation on 09/26/25 at 11:30AM of CNA A providing incontinent care for Resident #1. CNA A entered Resident #1's room wearing gloves and carrying a pack of disposable wipes. CNA A proceeded to transfer the resident from the wheelchair to her bed. CNA A proceeded to remove Resident #1's pants that were soiled in urine. Resident #1's brief was heavily soiled in urine. CNA A began to clean resident first starting with the buttocks clean back and forward with the same wipe instead of cleaning resident one wipe at a time. After cleaning resident buttocks, CNA A then placed a clean brief on resident without cleaning resident perineal area (area located between the anus and external genitalia in both male and females). After cleaning resident, CNA A then changed her gloves and placed cleaned pants on resident. Interview on 09/26/25 at 11:37AM, Resident #1 said the last time her brief had been changed was on the night shift around 5:30AM. The resident said she had not refused care. Interview on 09/26/25 at 11:45AM with CNA A said she worked at the facility full time for over 2 years. CNA A said she worked the 6AM-6PM shift. CNA A said she was supposed to wash her hands before placing on gloves to care for Resident #1. CNA A said Resident #1 was a heavy wetter. CNA A said she should have cleaned Resident #1 from front to back instead of starting with resident buttocks. CNA A said providing incontinent care at least every 2-hours and as needed, cleaning the residents thoroughly from front to back was important in preventing the spread of bacteria that could lead to urinary tract infections. CNA A said the reason she was making mistakes was because she was nervous. CNA A said she was not the CNA for Resident #1 and that CNA B was. CNA A said she was just helping CNA B. Interview on 09/26/25 at 12:45PM the DON said incontinent care should be provided to the residents every 2 hours and as needed. Interview on 09/26/25 at 1:25PM CNA B said she worked at the facility from 6AM-6PM full time since July of 2025. CNA B said she was the CNA assigned to Resident #1. CNA B said the last time she provided incontinent care for Resident #1 was between 7:30AM or 7:45AM but missed the next round for incontinent care. CNA B said incontinent care should be provided to the residents at least every 2 hours and that was the facility policy. Record review of the Nursing facility policy on Perineal Care dated February 2018 reflected in part: .The purpose of this policy procedure are to provide cleanliness and comfort to the resident to prevent infection and skin irritation, and to observe the resident's skin condition.For female residents.wash perineal area front to back separate the labia and was area downward form front to back.Continue to wash the perineum moving from inside outward to the thigh, rinse perineum thoroughly in same direction, using fresh water and a clean washcloth.rinse and dry thoroughly |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain, and infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections for 1 of 5 (Resident #1) reviewed for infection control. -CNA A did not practice hand washing/hand hygiene prior, during, and after providing incontinent care for Resident #1 -CNA A did not transport soiled linen in plastic bag. -CNA A removed disposable wipes from Resident #1's room and placed them back on cart in the hallway. These failures placed residents at risk for infections and cross contamination. Findings: Record review of Resident #1's face sheet dated 09/06/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and again on 05/08/24. Resident diagnoses included age related cataract, overactive bladder, hemiplegia (complete paralysis or loss of strength on one side of the body) and hemiparesis (partial weakness or loss of muscle strength on one side of the body) following cerebral infarction (when blood flow to the brain is disrupted), epilepsy (when nerve cell activity in the brain is disrupted, causing seizures), and anxiety (continuous worry, fear, and nervousness that can interfere with daily life). Record review of Resident #1's MDS dated [DATE] reflected a BIMS score of 15 indicating that resident cognition was intact. Further review section GG Functional abilities reflected that resident was dependent on toileting hygiene and required partial to moderate assistance with personal hygiene. Further review section H-Bladder and Bowel reflected that Resident #1 was always incontinent with urine and frequently incontinent of bowel. Record review of Resident #1's Comprehensive Care Plan dated 05/16/24 and revised 08/01/25 revealed that resident was being care planned for bladder incontinence. Observation on 09/26/25 at 11:30AM of CNA A providing incontinent care for Resident #1. CNA A entered the resident room wearing gloves and carrying a pack of disposable wipes. CNA A proceeded to transfer the resident from the wheelchair to her bed. CNA A proceeded to remove Resident #1's pants that were soiled in urine. Resident #1's brief was heavily soiled in urine. CNA A did not change gloves and sanitize her hands instead, proceeded to provide incontinent care. When CNA A completed incontinent care, she did not change gloves, wash or sanitize her hands but proceeded to transport the soiled linen in her hands walking out of the room down the hallway. After CNA A placed the soiled linen inside of the barrel, she removed her gloves and sanitized her hands. CNA A returned to Resident #1's room and removed the package of disposable wipes from resident room and placed the wipes back on the cart in the hallway. Interview on 09/26/25 at 11:45AM with CNA A said she worked at the facility full time for over 2 years. CNA A said she worked the 6AM-6PM shift. CNA A said she was supposed to wash her hands before placing on gloves to care for Resident #1. CNA A said soiled linen was supposed to be transported inside of a bag for infection control. CNA A said she was instructed not to leave disposable wipes in a resident's room when done providing care, but to return them to the cart in the hallway. CNA A said she was told this because staff were overstocking the resident rooms with personal care items. CNA A said she received in-service on this last week. CNA A said the reason she was making mistakes was because she was nervous. Interview on 09/26/25 at 12:45PM the DON said she was the Infection Control Preventionist. The DON said the staff should be practicing hand hygiene before, during, and after care. The DON said soiled linen should be transported in a bag for infection control and to prevent cross contamination. The DON said once personal care items including disposable wipes are taken in the resident room, staff should not be taking them out of the room to place back on the cart. The DON said this placed the residents at risk for cross contamination. The DON said the staff was in-serviced on not leaving personal care items at the bedside but inside the resident drawer. Record review of the facility policy on Infection Control dated October 2018 reflected in part: .This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of disease and infections. Record review of the facility policy on Departmental (Environmental Services) Laundry and Linen dated January 2014 reflected in part: .The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen.Consider all soiled linen to be potentially infectious and handle with standard precautions. Record review of the facility policy on Handwashing/Hand Hygiene dated October 2023 reflected in part: .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other |