STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676304	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Village	914 N Brazosport Blvd 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that the resident representative was promptly notified of a significant change in the resident's condition for 1 of 7 Residents (Resident #1) reviewed for notification. Specifically, the facility did not notify Resident #1's RP following an unwitnessed fall that occurred on 3/19/2026. This failure has the potential to delay the representative's involvement in the resident's care and decision making. The findings included: Record review of Resident #1's face sheet dated 4/09/2026 revealed a [AGE] year-old male admitted to the facility on [DATE], readmitted on [DATE] and discharged on 04/03/2026 with diagnoses that included traumatic subdural hemorrhage(injury causing bleeding under the outer covering of the brain), Peripheral vascular disease (poor blood flow in the vessels outside of the heart and brain), dementia (a decline in memory and thinking that makes it hard to do everyday activities), legal blindness, and repeated falls. Record review of Resident #1's MDS 5-day reentry assessment dated [DATE] revealed the resident has a severely impaired vision and BIMS was zero, which indicated severely impaired cognition and resident needs maximal assistance with activities of daily living. Record review of Resident #1's care plan dated 4/09/2026 revealed Resident #1 was High risk for falls r/t Vision/ problems, weakness. Resident #1 had falls on 1/18/26 unwitnessed no injury, 1/19/26 fall from wheelchair reaching to get shoes no injury, 02/09/2026 - fall during staff assistance, and 3/19/2026 - unwitnessed no injury and c/o pain to right hip, X-ray ordered- no fracture. Interventions included: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Educate CNAs, when getting resident up in the morning CNAs need to make sure residents are fully dressed. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. Record review of the facility's incident log dated 4/09/2026 revealed that Resident #1 sustained an unwitnessed fall on 3/19/2026. Further review of the incident documentation dated 3/19/2026, indicated that the DON and the physician were notified. However, there was no documentation to indicate that Resident #1's RP was notified of the incident. During an interview with Resident #1's RP on 4/9/2026 at 9:35 a.m., she stated that her father (Resident #1) had a fall on 3/19/2026 and no one from the facility notified her of the fall. During an interview with RN F on 4/9/2026 at 1:19 p.m., she stated that Resident #1 was identified as a fall- risk resident and sustained an unwitnessed fall on 3/19/2026, during the night shift. She stated that the incident occurred during the night shift and she was unaware of the reason the assigned nurse did not notify the RP. She indicated that notification should have occurred either during the night shift or been communicated to the day shift for follow - up. She further stated that she was unaware the RP had not been notified, as this information was not communicated to her during shift report. She stated failure to notify the RP compromises effective communication and advocacy for the resident and limits the family's awareness of the resident's condition and care needs. During an interview with DON on 4/9/2026 at 2:15 p.m., she stated that Resident #1 was identified as a fall-risk resident and had fall interventions in place. The DON stated upon review of the report, the DON noted that the nurse documented notification of the physician and the administrator; however, there was no (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation that the RP had been notified. She stated that, based on information obtained from the nurse, the nurse chose not to notify the family during the night shift to avoid disturbing them. The DON further stated that she did not know why the information was not communicated during shift report so the day shift nurse could follow up with the notification. The DON stated that the facility expectation was that any fall, whether witnessed or unwitnessed and with or without injury, was considered a change in condition and must be reported through the appropriate channels, including notification of the RP. The DON stated that failure to notify the RP could prevent the family from being aware of the resident's condition, delay decision-making, and limit their ability to participate in the resident's care and welfare. During an interview with Administrator on 4/10/2026 at 11:55 a.m., she stated she was aware that Resident #1 sustained a fall on 3/19/2026; however, she was not aware that the RP had not been notified. She stated that facility's expectation was that any fall, whether witnessed or unwitnessed, was considered a change in condition and must be reported, including notification of the resident's RP. Upon review of the incident report for that date, there was no documentation indicating that the RP was notified. The Administrator stated that although the incident occurred after midnight, the nurse could have communicated the information to the day shift for follow-up; however, she was unable to explain why this did not occur or why the RP was not notified.The Administrator stated that failure to notify the RP may result in delayed communication, lack of timely intervention, and limited involvement of the resident's representative in care decisions. During an interview with ADON on 4/10/2026 at 12:12 p.m., ADON stated that when a resident falls, staff are expected to obtain vital signs, initiate neurological checks, notify the DON and Administrator, physician and RP of the resident. She stated that notification should still occur, even if delayed until morning. She further stated that failure to notify the RP would prevent proper communication and advocacy for the resident and limit the family's awareness of the resident's condition and care needs. During an interview with LVN C on 4/10/2026 at 12:28 p.m., she stated she was not informed the RP had not been notified of the unwitnessed fall dated 3/19/2026, and it was not reported during shift change. She stated that in the event of fall, staff are expected to RP of the resident. She stated that failure to notify the RP would prevent family awareness of potential injuries and delay the representative's involvement in the resident's care and decision making. During a telephone interview with LVN B on 4/14/2028 at 7:58 a.m., LVN B stated that the incident occurred during the night shift. She stated that she notified the physician and the Administrator; however, she did not notify Resident #1's RP because it occurred in the middle of the night, there was no apparent injury, and she did not want to wake the family. LVN B stated that she reported the incident to the day shift nurse but was unable to recall the name of the nurse. She stated that the RP may not be aware of changes in the resident's condition, which could impact ability to make informed decisions regarding the resident's care and services if not notified. She stated that she was expected to notify the RP but failed to do so due to the time of the incident and concern about disturbing the family. Record review of the facility document titled Resident Rights revised on February 2021, and document titled Falls - Clinical Protocol revised in March 2018, did not address the facility's notification of falls to resident responsible party.