STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265607	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcreek Wellness & Rehabilitation	250 New Florissant Road South Florissant, MO 63031

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide services based on acceptable standards of practice by not clarifying a physician order for one resident who was not being monitored throughout the day for his/her diabetes (Resident #2) and for failing to complete a follow up accucheck (blood sugar test) per physician order for one resident who had elevated blood sugar (Resident #5). The sample was 5. The census was 104.Review of the facility's Physician Orders Policy, revised dated June 2020, showed:-Purpose: This will ensure that all physician orders are complete and accurate;-Policy: The medical records department will verify that physician orders are complete, accurate and clarified as necessary;--A licensed Nurse will transcribe telephone orders with date, time, and signature of the person receiving the order;-Orders will include a description complete enough to ensure clarity of the physician's plan of care;-Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order;-Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care disciplines will be transcribed onto the communication system for that discipline;-Documentation pertaining to the physician order will be maintained in the resident's medical record. Current month's administration record will be maintained in the medication administration record (MAR)/treatment administration record (TAR). Review of the facility's Diabetic Care Policy, revised dated June 2020, showed:-Purpose: To improve the quality of care delivered to the residents with diabetes;-Policy: Blood glucose levels will be monitored at specific intervals as ordered by the attending physician;-The resident will be monitored for signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar);-Procedure: The License Nurse will monitor the resident blood glucose per the Attending Physician's order and will administer the medication as indicated;-Notify the Attending Physician if blood sugar is outside of the ordered parameters;--Of treatment and results;--For any possible changes in insulin and oral diabetes medication;-Document the episode in the resident's medical record including;--Resident's symptoms;--Interventions;--Resident's response to treatment;--Physician notification. 1.Review of Resident #2's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/15/25, showed:-Cognitive intact;-Needs moderate assistance with activities of daily living (ADLs). Review of the resident's electronic medical record (EMR), showed diagnoses included diabetes and kidney failure. Review of the resident's hospital after-visit summary, dated 5/2/25, showed continued medications included insulin aspart (a short-acting insulin) 100 unit (U)/milliliter (ml) vial for injection, inject (administer) 6U under the skin every eight hours as needed (PRN). Review of the resident's physician order sheet (POS), showed:-An order, dated 5/2/25, for insulin aspart, inject 6U under the skin every eight hours PRN;-No physician order to check the resident's blood sugar. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Is at risk for abnormal blood sugars related to diabetes;-Goal: Will be (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	free from any signs and symptoms of hypoglycemia and hyperglycemia through the review date;-Interventions included diabetes medication as ordered by doctor;-No documentation related to the resident's refusals of accuchecks and/or insulin administration. Review of the resident's MARs, showed insulin aspart not documented as administered from May 2025 through January 2026. During an interview on 1/7/26 at 10:13 A.M., the Medical Director said he expected staff to follow physician orders. He was unaware if there is an order for completion of accuchecks in the resident's POS. He did not know if the hospital ordered accuchecks. He expected facility staff to check the resident's blood sugars two times daily and to administer the insulin aspart as ordered if the resident had elevated blood sugar levels. During an interview on 1/7/26 at 10:30 A.M., Assistant Director of Nurses (ADON) B said facility staff should have clarified the orders from the resident's hospital after visit-summary, since it said to administer insulin aspart every eight hours PRN. During an interview on 1/7/26 at 10:59 A.M., the Medical Director said due to the resident's refusals, it was hard to obtain the resident's accuchecks and administer his/her insulin. He did not believe the resident's refusals were care planned. 2. Review of Resident #3's admission MDS, dated [DATE], showed:-Cognitively intact;-Wheelchair;-Hoyer (mechanical) lift;-Dependent (resident needs assistance from two or more people) with ADLs. Review of the resident's EMR, showed:-admission date 7/1/20;-Diagnoses included diabetes, hepatitis C (infection of the blood), obstructive sleep apnea (ineffective breathing while sleeping), morbid obesity (overweight), and altered mental status (disorder that affects brain function). Review of the resident's care plan, in use at the time of survey, showed:-Focus: Has diabetes without complications;-Goal: Will be free from any signs and symptoms of hyperglycemia through the review date. Review of the resident's POS, showed:-An order, dated 7/2/25, for insulin lispro (Humalog, a short-acting insulin), inject per sliding scale, under the skin every eight hours PRN;-An order, dated 7/2/25, for insulin glargine (Lantus, a long acting insulin) 100 unit/ml, inject 20U subcutaneously (fatty part of the body) at bedtime. Review of the resident's progress notes, showed:-On 1/5/26 at 5:09 P.M., the resident's blood glucose was 484. Nurse contacted the Medical Director, who ordered 24U of Lantus and 12U of Lispro with an accucheck within two hours;-The next blood sugar check was confirmed at 1/6/26 at 7:05 A.M., blood glucose level was 113;-No documentation of blood sugar checked between 1/5/26 at 5:09 P.M. and 1/6/26 at 7:05 A.M. During an interview on 1/7/26 at 1:28 A.M., ADON B said she expected staff to follow the facility's policy and procedures. She expected Certified Medical Technicians (CMTs) to assist with accuchecks and insulin administration if the LPNs or Registered Nurses (RNs) are running behind or needing help. This is a task that can be delegated to the CMTs. During an interview on 1/7/26 at 2:00 P.M., the Administrator said the Director of Nursing (DON) and ADONs should follow up on all orders written from the Medical Director.