STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675525	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Park Rehabilitation Health Care Center	1000 Fm 3220 Clifton, TX 76634

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on observation, interview and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one of six residents (Resident #1) reviewed for abuse. The facility failed to protect Resident #1 from abuse when CNA A placed her hand over Resident #1's mouth to keep her from talking while she provided care to the resident. This failure could place residents at risk of experiencing and enduring abuse by facility staff causing a decreased quality of life. Findings include: Record review of Resident # 1's face sheet dated, 10/21/2024, reflected a [AGE] year-old female with an admitted [DATE] . Resident # 1 had diagnoses of unspecified dementia(memory loss), Alzheimer's(memory loss), cognitive communication deficit(difficult paying attention to conversation), and major depressive disorder(loss of interest in activities). Record review of Resident # 1's admission care plan, dated 09/23/2024, reflected Resident #1 had impaired thought process r/t to dementia. Interventions to identify yourself at each interaction, face the resident when speaking , and make eye contact. Record review of Resident # 1's admission MDS, dated [DATE] reflected a BIMS score of 3, which indicated cognitive impairment. Record review of the facility's incident report, dated 10/03/2024 and 10/04/2024, did not reflect any report of the incident in PCC. Record review of - progress notes, dated 10/03/2024 and 10/04/2024 did not reflect any documentation of the abuse. Record review of Resident #1's assessments did not reflect any head-to-toe documentation on 10/03/2024 and 10/04/2024. (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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NAME OF PROVIDER OR SUPPLIER Willow Park Rehabilitation Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Fm 3220 Clifton, TX 76634	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident's 2's face sheet, dated 10/21/2024 reflected a [AGE] year-old female with an admitted [DATE]. Resident #2 had diagnoses which included heart failure(heart does not pump well as it should), hypertension(force against artery walls to high), and diabetes(too much sugar in the blood) Record Review of Resident's 2's admission MDS, dated [DATE], reflected a BIMS score of 13,which indicated cognition was intact. Observation of Resident #1 on 10/21/2024 at 1:20 PM revealed the resident was laying in the bed with her two dolls. Resident # 1 was unable to tell anything about the incident or if anything had happened to her with CNA A. Unable to interview Resident #2 on 10/21/2024 due to her passing away after the incident. Unable to interview the ADM due to her being out of the country on vacation. Attempted phone interview with CNA A on 10/21/2024 at 1:30 PM was unsuccessful. Left a voice message for her to return call with no response. Attempted interview with Resident #1's RP on 10/21/2024 at 1:38 PM was unsuccessful. Unable to leave a voice message. In an interview on 10/21/2024 at 11:45 AM with the DON revealed Resident # 2 made a report to CNA C on 10/03/2024 around 10:00 PM that CNA A had placed her hands around Resident #1's mouth to prevent her from talking while she was providing care to her. The DON stated Resident # 2 had a BIMS of 13 and was cognitively intact. The DON stated she was contacted right after the report was made to CNA C and immediately, she contacted CNA A by phone to let her know she was suspended pending the outcome of the investigation. Once the investigation was confirmed shortly after , CNA A was contacted by phone and advised she was terminated. The DON stated what CNA A did was abuse and abuse was not tolerated. The DON stated that abuse could lead to injuries to residents. In an interview on 10/21/2024 at 4:00 PM with LVN B revealed CNA C reported to her a little after 10:00 PM on 10/03/2024 what Resident # 2 reported to her that CNA A placed her hand over Resident # 1's mouth while providing care. LVN B stated she spoke with Resident # 2, and she told her the incident happened on the 2:00 PM- 10:00 PM shift but the time was not recalled. Resident # 2 told her she did not really want to tell CNA C or her, in fear of being retaliated against. Resident #2 told her when CNA A came in the room to assist Resident # 1, CNA A told Resident # 1 not to talk to her anymore and CNA A placed her hand over Resident #1's mouth to keep her from talking. LVN B stated she immediately contacted the ADM and assessed Resident #1. LVN B stated there was no actual harm and Resident # 1 did not remember anything about the incident. In an interview on 10/21/2024 at 5:48 PM with CNA C revealed she went to assist Resident # 2 with care around 10:00 PM on 10/03/2024. Resident # 2 asked her if she could tell he a secret and told her CNA A was assisting with care earlier for Resident # 1 and had placed her hand over her mouth to shut her up because she was talking to her. CNA A told Resident # 1 not to talk to her anymore. CNA C stated she immediately reported to LVN B and LVN B spoke with Resident # 1 and assessed her for harm. CNA C stated LVN B assessed Resident # 1 and there was no harm. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled abuse prohibition dated 01/01/2024 and reviewed 05/17/2024 reflected This protocol was intended to assist in the prevention of abuse, neglect, and misappropriation of property. Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interview and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were complete and accurately documented for one of six residents (Resident #1) reviewed for accurate medical records. The facility failed to ensure Resident #1's medical chart contained incident reports, assessments , and nursing progress notes of an incident dated 10/03/2024 or 10/04/2024. This deficient practice could place residents at risks of errors in care and treatment. Findings include: Record review of Resident # 1's face sheet dated 10/21/2024 reflected a [AGE] year-old female with an admitted [DATE] . Resident # 1 had diagnoses of which included unspecified dementia(memory loss), Alzheimer's(memory loss), cognitive communication deficit(difficult paying attention to conversation), and major depressive disorder(loss of interest in activities). Record review of Resident # 1's admission care plan dated 09/23/2024, reflected Resident #1 had impaired thought process r/t to dementia. Interventions to identify yourself at each interaction, face the resident when speaking , and make eye contact. Record review of Resident # 1's admission MDS, dated [DATE] reflected a BIMS score 3, which indicated cognitive. impairment. Record review of the facility incident report, dated 10/03/2024 and 10/04/2024 did not reflect any report of the incident in PCC. Record review of - progress notes, dated 10/03/2024 and 10/04/2024 did not reflect any documentation of the incident. Record review of assessments did not reflect any head-to-toe assessment documentation on 10/03/2024 and 10/04/2024. In an interview on 10/21/2024 at 4:00 PM with LVN B stated once she assessed Resident # 1, she documented the assessment , entered the notes, and the incident report right after assessing Resident # 1. LVN B stated she did not know what happened and why there was no documentation in the system when she placed it in there. LVN B stated incident reports and documentation was entered immediately. LVN B stated she was responsible for the documentation to be entered and was not sure what happened or why it was not in the system. LVN B stated documentation was important for communicating resident's care among staff. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/21/2024 at 5:28 PM with the DON revealed she checked for documentation on 10/3/2024 and 10/04/2024 and there was not any for either day. The DON stated once the incident was reported it was expected to be documented at least by the end of the shift. The DON stated documentation was important because if there was no documentation noted it meant that it did not happen. Record review of the facility policy titled charting and documentation, dated revised 07/2017, reflected All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.