

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Willow Park Rehabilitation Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to ensure all alleged violations involving neglect were reported to the State Survey Agency in a timely manner for 1 of 5 (Resident #) residents reviewed for abuse and neglect. The facility failed to report an incident to the state survey agency when Resident #1 had a choking episode while eating, resulting in death, after staff failed to activate 911 emergency response on 06/13/2025. The failure could place residents at risk of physical harm, pain, mental anguish, or death. Findings included: Record review of Resident #1's clinical resident profile reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of diabetes type 2 (elevated blood sugar), vascular dementia (difficulty thinking and processing thoughts), major depressive disorder, and anxiety. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS of 11, which indicating mild cognitive impairment. It also indicated Resident #1 did not have any swallowing disorders such as holding food in his mouth, coughing, or choking during meals or difficulty or pain with swallowing. Record review of Resident #1's care plan dated 01/17/2024 reflected: Receives Therapeutic and Mechanically soft Diet, Resident has decreased appetite with poor meal intake at times. Interventions included: Assist resident with meals as needed. Set up meal tray, open beverages, cut foods, provide assistance as needed. Record review of Resident #1's progress notes dated 06/13/2025 reflected At approximately 5:20, PM CNA heard calling out for help. This nurse entered Dining room and noted resident gasping and coughing. CNA stated that resident was eating dinner and began choking on his food. Noted mech soft dinner tray in front of resident, consistent with resident's diet orders. This nurse assessed Resident's mouth and noted food in airway. Finger sweep attempted while visualizing food without success. This nurse started abdominal thrusts and sent CNA to alert another nurse for additional assistance. LVN B arrived, and this nurse and attempted abdominal thrusts several more times without success. Resident's respirations ceased and pulse was unobtainable. Code status confirmed as DNR. No signs of life noted. Notified PCP, RP, and DON. Signed by LVN A In an interview on 07/08/2025 at 1:00 pm, the VA Nurse stated she reviewed the incident at her monthly visit to monitor the VA contract residents that reside at the nursing facility. She stated she asked the facility DON why 911 was not notified. She stated the DON stated that the facility was honoring the residents DNR wishes. She stated that the facility's failure to activate emergency services by calling 911 during the choking episode, was a reportable incident. The VA nurse stated that Resident #1 having a DNR on file did not mean that the facility should not treat him if he was choking. She stated the ADM and DON told her it was not reportable because they were aware of the incident, and it was not under suspicious circumstances that followed their policy. In an interview on 07/09/2025 at 3:15 pm, the DON stated she was the back up for reporting significant events to state when the ADM was out of the building. She stated the incident involving Resident #1 was not reported because it was not suspicious. She stated they knew exactly what happened. She stated she did not think it was neglectful that 911 was not called because it would not have changed the outcome. In an interview on 07/09/2025 at 3:47 pm, the ADM stated she was responsible for reporting incidents to the state if needed. She stated the incident involving Resident #1's death was not reportable because the facility knew the situation, there was no abuse or neglect, and they followed policy. She stated she did not know how to answer if not calling 911 was neglectful. Record review of the facility's policy titled Abuse Prohibition Policy reviewed 06/02/2025 reflected: The facility will report all allegations and substantiated occurrences of abuse, neglect or misappropriation of resident property to the state agency and to all other agencies as required by law and will take all necessary corrective actions depending on the results of the investigation. The Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, exploitation with serious bodily injury, and injuries of unknown source with serious bodily injury immediately or within two hours of the allegation. The Abuse Coordinator will report all other allegations of neglect, mistreatment, exploitation, injuries of unknown source and misappropriation within 24 hours of the allegation. Record review of the facility's policy titled Resident Incident and Visitor Accident Report reviewed 10/08/2020, [DATE] and June 2024 reflected: The facility will conduct an investigation of all incidents involving residents of the facility. The facility will conduct an investigation of all non-resident accidents that occur on the property of the facility. The investigation will be conducted by designated personnel and reported to the Administrator/designee. Incidents/Accidents of Unknown Origin will be reported in accordance with state and federal regulations</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 5 (Resident #1) residents reviewed for quality of care. The facility failed to activate 911 emergency services response on 06/13/2025 for Resident #1 when he had a choking episode while eating resulting in his death. An IJ (Immediate Jeopardy) was identified on 07/08/2025. The IJ template was provided to the facility on [DATE] at 5:12 PM. While the IJ was removed on 07/10/2025, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy. This failure could place residents at risk of physical harm, pain, mental anguish, or death. Findings included: Record review of Resident #1s clinical resident profile reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnosis of diabetes type 2 (elevated blood sugar), vascular dementia (difficulty thinking and processing thoughts), major depressive disorder, and anxiety. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS of 11, which indicating mild cognitive impairment. It also indicated Resident #1 did not have any swallowing disorders such as holding food in his mouth, coughing, or choking during meals or difficulty or pain with swallowing. Record review of Resident #1's care plan dated 01/17/2024 reflected: Receives Therapeutic and Mechanically soft Diet, Resident has decreased appetite with poor meal intake at times. Interventions included: Assist resident with meals as needed. Set up meal tray, open beverages, cut foods, provide assistance as needed. Record review of Resident #1's progress notes dated 06/13/2025 reflected At approximately 1720, CNA heard calling out for help. This nurse entered Dining room and noted resident gasping and coughing. CNA stated that resident was eating dinner and began choking on his food. Noted mech soft dinner tray in front of resident, consistent with resident's diet orders. This nurse assessed Resident's mouth and noted food in airway. Finger sweep attempted while visualizing food without success. This nurse started abdominal thrusts and sent CNA to alert another nurse for additional assistance. LVN B arrived, and this nurse and attempted abdominal thrusts several more times without success. Resident's respirations ceased and pulse was unobtainable. Code status confirmed as DNR. No signs of life noted. Notified PCP, RP, and DON. Signed by LVN [NAME] an interview on 07/08/2025 at 1:00 pm, The VA Nurse stated she reviewed the incident at her monthly visit to monitor the VA contract residents that reside at the nursing facility. She asked the facility DON why 911 was not notified. She stated the DON stated that the facility was honoring the residents DNR wishes. She stated that the facilities failure to activate emergency services by calling 911 during the choking episode was a reportable incident. The VA nurse stated that Resident #1 having a DNR on file did not mean that the facility should not treat him if he was choking. The facility stated they followed their policy they did not call 911 because the resident did not lose consciousness until the very end of the choking episode and at that time he had no pulse. She stated the ADM and DON told her it was not reportable because they were aware of the incident, and it was not under suspicious circumstances that followed their policy. In an interview on 07/08/2025 at 1:46 pm, LVN A stated on 6/13/25 she was passing the dinner trays out to the residents on the secure unit when the CNA working with her started yelling for help. Resident #1 was choking so she did a mouth sweep and a visual check on his mouth. LVN A stated Resident #1 continued to choke so she began chest thrust and was unsuccessful. She sent the CNA to get assistance and 2 more LVNs came to attempt the chest thrust. The Choking episode all happened so quickly no one initiated a 911 call. She stated the resident went limp and no longer was breathing. LVN A stated the nurses checked his code status, and it as DNR. They called their supervisor who told them to honor the DNR. LVN A stated an RN later came and pronounced the resident's time of death at the facility. LVN A stated their policy stated if the resident was a DNR, they did not have to call 911. Normally if choking were to happen, they would call 911, but staff were trying to get his airway clear. The DON showed the policy to staff that stated if a resident actively passes during emergency treatment, and they had a DNR, the nurse did not have call 911 emergency services. LVN A stated negative effects for not having 911 emergency services dispatched during an emergency such as choking could be that the resident could die. In an interview on 07/08/2025 at 1:57 pm, LVN B stated he was called to the secure unit with a suction machine and responded to Resident #1's choking. He took the suction machine to the secure unit and began assisting with the Heimlich maneuver. LVN B stated he was doing the chest thrust so he was not aware of</p>		