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	05/20/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 1 of 5 residents (Resident #1) reviewed for resident rights. The facility failed to ensure Resident #1's call light was within reach on 05/20/26. This failure could place residents at risk of their needs not being met.Findings included: Record Review of Resident #1's face sheet dated 05/20/26 reflected the resident was a [AGE] year-old male admitted on [DATE]. His diagnoses included bipolar disorder (a chronic mental health condition characterized by extreme mood swings, alternating between intense highs (mania or hypomania) and severe lows (depression)), muscle wasting and atrophy (the loss of muscle tissue and strength, typically caused by inactivity, malnutrition, aging (sarcopenia), or diseases affecting nerves or muscles), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), and peripheral vascular disease, also known as peripheral artery disease, (a condition that occurs when blood vessels narrow or become blocked, reducing blood flow to the body. Peripheral vascular disease can affect any blood vessel outside of the heart, but it most commonly affects the legs and feet). Record Review of Resident #1's Annual MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 13 which indicated Resident #1 was cognitively intact. The MDS reflected Resident #1 required setup or clean-up assistance for eating and was dependent on staff for toileting, showering, and personal hygiene. Record review of Resident #1's care plan dated 06/06/21 and revised 08/06/25 reflected: Resident had an ADL self-care performance deficit r/t quadriplegia (the partial or total loss of motor and sensory function in all four limbs ((arms and legs)) and the torso) from anoxic brain injury (when the brain is completely deprived of oxygen, leading to cell death within minutes), and contracture (a permanent, or long-lasting, tightening of muscles, tendons, ligaments, or skin that causes joints to become stiff and rigid, limiting mobility). Resident has need for assistance with personal care.Goal: Resident #1 would maintain current level of function in ADLs through the review date with target date: 07/06/26.Interventions included: Encourage the resident to use bell to call for assistance. During an observation and interview on 05/20/26 at 9:36 AM, Resident #1 stated he was doing ok and the staff here treated him well. He stated he had a way to call for help but he could not have reached it at this time if he tried. Resident #1's call light was observed under Resident #1's bed wrapped around the bed frame and hung near the floor, out of resident's reach. He stated if he needed help, he would have had to yell for someone because he would not have been able to get to his light. Resident #1 demonstrated that he could not reach his call light where it was placed. During an interview on 05/20/26 at 9:54, AM CNA C stated Resident #1 was alert enough to be able to tell her if he needed something and he called staff whenever he needed them to do something. She stated he yelled for help and he used his call light when he needed help. She stated Resident #1 could not have reached his call light where it was placed. She stated all residents' call lights should have been within their reach at all times. She stated she had been trained on call lights being within residents' reach at all times. She stated if a resident's call light had not been within their reach, they would not have been (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	able to get ahold of staff if they needed something. During an interview on 05/20/26 at 10:21 AM, LVN A stated she had worked in the facility for about a year and a half. She stated she had been in-serviced on call light placement within residents reach at all times and resident rights. She stated all residents call lights should have been within reach at all times. She stated if a resident's call light was not in reach it could have caused a fall or a resident could have been in pain and could not have been able to call for staff. During an interview on 05/20/26 at 10:32 AM, CNA D stated she had worked in the facility for about 4 years. She stated she had been in-serviced on call light placement within residents' reach at all times and resident rights. She stated all residents' call lights should have been within reach at all times. She stated if a resident's call light was not in reach it could have caused something bad like a fall to happen. During an interview on 05/20/26 at 10:37 AM, LVN B stated she had worked in the facility for about a year and she worked on the secured unit. She stated she had been in-serviced on call light placement within residents' reach at all times and resident rights. She stated all residents call lights should have been within reach at all times. She stated if a resident's call light was not in reach it could have caused a resident to fall and not be able to get help in time or could have been having a serious issue and may not have been able to get the help they needed. During an interview on 05/20/26 at 10:48 AM, CNA E stated she had worked in the facility for about 4 years. She stated she had been in-serviced on call light placement within residents reach at all times and resident rights. She stated all residents' call lights should have been within reach at all times. She stated if a resident's call light was not in reach it could have caused a resident to fall and not have been able to call for help or a resident may have needed water or something and would not have been able to get staff. During an interview on 05/20/26 at 1:31 PM, the DON stated staff had been trained on call light placement within residents' reach and resident rights. She stated all residents' call lights should have been within reach at all times. She stated if a resident's call light was not in reach it could have caused the resident to not be able to get to staff when they needed help. During an interview on 05/20/26 at 1:43 PM, the ADM stated staff had been in-serviced on call light placement within residents' reach at all times and resident rights. She stated all residents' call lights should have been within reach at all times. She stated if a resident's call light was not in reach it could have caused a resident to fall or a resident may have been unable to let staff know they needed something. Record review of facility policy titled Answering the Call Light dated 2001 and revised September 2022 reflected Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines: 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. Record review of facility policy titled Resident Call System dated October 2022 and reviewed 03/28/2023 reflected Policy: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Policy Interpretation and Implementation: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. Calls for assistance are answered as soon as possible. Urgent requests for assistance are addressed immediately.