

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/19/2025
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse for 5 (Resident #6, Resident #11, Resident #57, Resident #84, and Resident #85) of 13 residents reviewed for abuse. The facility failed to ensure the safety of Resident #84 on 12/3/25 when Resident #11 hit him in the chest causing the resident to fall and hit the ground hard resulting in Resident #84 being sent out to the hospital for evaluation of injuries. The facility failed to ensure the safety of Resident #85 on 11/19/25 when Resident #11 punched him in the face. The facility failed to ensure the safety of Resident #6 on 11/22/25 when Resident #11 pushed him to the ground. The facility failed to ensure the safety of Resident #57 on 12/9/25 when Resident #11 hit him on the arm. An Immediate Jeopardy (IJ) was identified on 12/16/2025. The IJ template was provided to the facility on [DATE] at 4:45 PM. While the IJ was removed on 12/18/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on abuse/neglect. This failure placed residents at risk of abuse, trauma, and/or psychosocial harm. Findings included: Review of Resident #11's quarterly MDS dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: Alzheimer's (mental deterioration), depression (persistent feelings of sadness and loss of interest), bipolar (periods of depression and abnormally elevated mood), anxiety (feelings of worry, nervousness, or unease), and mood disorder (imbalance of brain chemicals that can lead to long periods of extreme happiness, extreme sadness, or both). Resident #11 had a BIMS score of 01, indicating severely impaired cognition. His most current height was 6ft 9in and his weight was 238.4lbs. In section E - Behavior it was indicated that within the last 1 to 3 days Resident #11 exhibited physical behavioral symptoms toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) Review of Resident #11's comprehensive care plan dated 12/16/2025 reflected, The resident is physically aggressive at times r/t Demential can be combative with staff during care and also be resistant to care at times.08/06/2025 I have been physically aggressive with another resident.10/11/2025 I initiated physical aggression toward a peer.10/22/2025- I initiated physical aggression toward my peers and staff members X2 this day.10/23/2025- I initiated physical aggression toward my peers and staff members today11/15/2025- I initiated physical aggression toward my peers and staff members today. (while on 1:1)11/19/2025- I initiated physical aggression toward my peers and staff members today. (while on 1:1)11/22/2025- I initiated physical aggression toward my peer. (while on 1:1)12/03/2025- I initiated physical aggression toward my peer today. (while on 1:1)12/05/2025- resident became combative. After combative episode left knee skin tear noted. (while on 1:1)Resident #11 was put on 1:1 precaution on 11/11/2025 due to his behaviors with his peers. The goal was to have fewer episodes of aggressive behaviors, and no evidence of behavior problems (aggression/agitation and/or anxiety). The interventions listed were to anticipate and meet the resident's needs, caregivers to provide opportunity for positive interactions, attention, and to stop and talk with Resident #11 when passing, and to praise any indication of progress/improvement in behavior. Review of Resident #85's (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675525 If continuation sheet Page 1 of 21

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Completion date: 12/16/25 and Ongoing Director of Nursing ensured that physical separation at arm's length was implemented between Resident #11 and all other residents at all times. Accomplished by in-services to all staff conducted by DON. Completion date: 12/16/25 and Ongoing Director of Nursing ensured resident #11 was placed in a controlled, low-stimulation environment Completion date: 12/16/25 and Ongoing Director of Nursing searched the memory care common area and Resident #11's room to ensure objects that could be used to cause harm were removed from the resident's environment. Completed 12/16/25 and ongoing Director of Nursing ensured a two-staff approach was implemented for all care interactions involving Resident #11. Completed 12/16/25 and ongoing Director of Nursing ensured a STAT psychiatric evaluation was requested for Resident #11 and completed on 12/16/25 by Psychiatric Nurse Practitioner. Medication changes and additional diagnosis resulted. Director of Nursing ensured the resident's medication regimen and PRN parameters were reviewed and adjusted as clinically indicated. Completed 12/16/25 On 12/16/25, the DON reviewed Resident #11's clinical status to assess for potential medical contributors to aggressive behavior. Pain assessment was completed and addressed. Vital signs and oxygen saturation were reviewed and within acceptable parameters. Infection screening was reviewed with no acute findings. Bowel and bladder status were assessed and addressed. Medication profile was reviewed for potential contributing side effects. No acute medical condition was identified contributing to behaviors. Findings were reviewed with the attending physician and psych provider. Plan of care was updated accordingly. Responsible: DON Systemic Actions Start: 12/16/25 The facility revised its process for managing residents with aggressive behaviors What behaviors , including early identification of triggers, defined escalation thresholds, and clear staff response expectations. Revised process includes Identification, Immediate Risk Mitigation, Interdisciplinary Care Planning, Staff Assignment, Protection of Others and Monitoring and Oversight. Completion date 12/16/25 Resident #11's behavioral care plan was revised by the interdisciplinary team to include identified triggers, early warning signs, de-escalation techniques, and clear direction for escalation. Completion date 12/16/25. Corporate Clinical Specialist educated DON and ADON regarding dementia-related aggressive behaviors, resident to resident abuse prevention, and de-escalation strategies. Validation completed by quiz. Completion date 12/16/25 DON and ADON conducted education for staff on all shifts regarding dementia-related aggressive behaviors, resident-to-resident abuse prevention, and de-escalation strategies. Staff, including PRN and Agency, will be unable to work until education is completed. Completion date 12/17/25. Staff education was validated by quiz that was completed and documented. Staff will be unable to work until education is completed and validated by quizzes. Minimum score of 100% is expected to pass. Completion date: 12/17/25 The Abuse Prevention Policy was reinforced with specific focus on resident-to-resident aggression. Completion date: 12/16/25 Pathways of resources for staff for psychiatric consultation and alternative placement consideration were reinforced. Pathways will be in binder and placed at the nurses' station for staff accessibility. Completion date: 12/17/25 A house-wide assessment was conducted by Corporate Clinical Specialist and DON to identify residents at risk for harm, and protective interventions were implemented. As a result of the assessment, all residents in memory care unit were at risk. Completion date 12/17/25. Responsible: DON Monitoring Start Date: 12/16/25 The DON, or designee, provides immediate oversight of supervision levels and resident safety related to aggressive behaviors. Charge Nurse provides real time supervision during each shift to ensure protective interventions and separation measures remain in place. Any escalation in aggressive behaviors result in immediate re-assessment and modification of interventions. Leadership maintains active presence in oversight to ensure continued resident safety and adherence to interventions implemented to remove the jeopardy. Resident-to-resident aggression is monitored through the QAPI program with trend analysis. Findings are reviewed by the QAPI Committee 1x a month for 6 months and corrective actions are implemented as needed. Ongoing audits are conducted to ensure compliance with supervision, care planning, and staff response protocols. Responsible: Administrator (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The surveyor monitored the POR on 12/18/2025 as follows: Review of a psychiatric progress note dated 12/16/25 at 6:45 PM for Resident #11 revealed a new order for Haldol 2 mg BID. Resident #11's current medications were listed along with his diagnoses, and notes from the NP. Review of assessments completed on Resident #11 dated 12/16/2025 revealed the following assessments were completed: infection screening, pain evaluation, bowel evaluation, bladder evaluation which all revealed no acute findings. A note from the DON revealed she conducted a medication review for potential interactions, also with no findings. Review of an in-service dated 12/16/2025 conducted by the CCS and titled Managing Residents with aggressive behaviors reflected the signatures of the DON and ADON. Review of an in-service dated 12/16/2025 conducted by the DON and ADON titled Managing Residents with aggressive behaviors reflected 80+ staff were in-serviced either in person or over the phone and a quiz was given to every staff ensuring a 100% passing. The in-service covered abuse and neglect prevention, management of aggressive behavior, dementia-related aggressive behavior, resident-to-resident abuse, and de-escalation strategies. Review of an in-service dated 12/16/2025 conducted by the DON, and titled 2:1 Safety revealed, staff must consistently remain with Resident #11 under strict precautions to ensure the safety of Resident #11, staff, and peers. Staff are required to remain attentive, free from distractions, and within arm's reach of the Resident at all times. A minimum of two (2) staff members must be present with the Resident at all times. The two assigned staff are responsible for ensuring that all other staff and peers remain at an arm's-length distance from the Resident at all times. There are no exceptions to these requirements; failure to remain attentive or to follow these precautions will result in disciplinary action. 27 staff signatures were visible on the sign in sheet, across departments. Review of a binder placed at both nurses' stations on 12/17/2025 titled, Resources for Managing Aggressive Behavior revealed steps for managing residents with aggressive behaviors, the facility policy on management of residents with aggressive behaviors, and an in-service for managing residents with aggressive behaviors. Review of a facility census revealed that the CCN and DON identified the residents in the secured unit were at risk of harm. Review of QAPI meeting sign in sheet dated 12/17/2025, revealed the signatures of the MD, RDO, CCS, and other department head signatures. Review of an audit/monitoring form for Resident #11 revealed his care plan was audited on 12/17/25 and staff supervision was monitored on 12/18. Review of undated staff competency quizzes which posed questions about managing residents with aggressive behaviors, triggers, and escalation pathway, revealed all 9 CNA's, 2 MA 's, 4 LVN's, 2 RN's, and 8 housekeeping and dietary staff interviewed achieved 100% passing. Review of Resident #11's updated care plan dated 12/17/2025 reflected the following updates: Resident is two persons on one r/t resident behaviors and/or aggressions with peers. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Staff to identify resident's triggers for behaviors and use de-escalation techniques. Staff to identify early warning signs for resident's behavior and triggers. Staff to identify resident's triggers for behaviors (loud noises, other peers in his personal space, people touching his clothing, he doesn't like to be changed when his clothing is soiled. Resident doesn't like crowded spaces.) Staff to identify early warning signs for residents' behaviors and triggers. (Resident starts fidgeting. Repeats words over and over and paces, starts pushing or pulling on staff.) In an observation/interview on 12/17/2025 at 9:04 AM, revealed 2 staff-CNA I and NA J stated they were assigned to work their 7am-7pm shift with Resident #11. They stated they were instructed by the DON that they were responsible for being within an arm's length away from Resident #11 and always keeping Resident #11 an arm's length away from his peers. They were to supervise him to ensure no altercations took place. They stated Resident #11 required 2 staff for care activities such as dressing, bathing, and changing. Resident #11 was observed sitting in a chair watching television in between CNA I and NA J. In interviews completed on 12/18/2025 between the time of 10:35 AM. and (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation and interview, the facility failed to ensure a resident has a right to personal privacy and confidentiality of his or her personal and medical records for 2 of 3 computers reviewed for privacy and confidentiality. On 12/18/2025 LVN O left the facility's computer open and unattended at the nurse's station with resident's personal medical information was visible to anyone who passed by. On 12/18/2025 LPN K left the facility's computer open and unattended at the nurse's station with resident's personal medical information was visible to anyone who passed by. On 12/19/2025 LVN O left the facility's computer open and unattended at the nurse's station with resident's personal medical information was visible to anyone who passed by. These failures could place residents at risk of having their private information changed, viewed, and not kept secure. Findings included: During an observation on 12/18/2025 at 1:17 p.m., reflected LVN O left her computer unlocked/opened and unsupervised, vaguely visible in an open area for residents and other individuals/guests of the facility passing by the nurse's station, with resident information visible on the screen. At the time of the observation LVN O left her computer and walked towards the administrator's office. During an observation on 12/18/2025 at 1:25 p.m., reflected LPN K left his computer unlocked/opened and unsupervised, vaguely visible in an open area for residents and other individuals/guests of the facility passing by the nurse's station, with resident information visible on the screen. At the time of the observation LPN K left his computer and walked down the D hall. During an observation on 12/19/2025 at 2:15 p.m., reflected LVN O left her computer unlocked/opened and unsupervised, vaguely visible in an open area for residents and other individuals/guests of the facility passing by the nurse's station, with resident information visible on the screen. At the time of the observation LVN O left her computer and walked down the A hall. During an interview on 12/19/2025 at 12:45 p.m., the ADON stated the nurse using the computer was responsible for ensuring residents' information was not displayed on the unattended computer. The ADON stated a negative outcome of an unattended computer was that residents' information could be accessed by anyone. The ADON stated her expectations were for staff to ensure resident information was not displayed on unattended computer screens. During an interview on 12/19/2025 at 1:20 p.m., the ADM stated it was the staff using the computer responsibility for ensuring the computer screen was locked when unattended. The ADM stated a negative outcome could be that someone would have access to a resident's personal information. The ADM's expectations moving forward was for staff to ensure their computer screens were locked when unattended. Record review of the facility's Resident Rights, revised dated 2016, reflected, Employees shall treat all resident with kindness, respect, and dignity. Policy Interpretation and Implementation: 3. The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPAA Compliance Officer .		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the resident has the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers for 1 (Residents #9) of 6 residents reviewed for resident rights. The facility failed to obtain an informed consent for the use of Ativan (an antianxiety medication) used for Resident #9. This failure could place residents at risk of receiving medications without prior consent and without the option to choose alternative treatment or decline based on awareness of risk and benefits of the medications. Findings included: Record review of Resident #9's comprehensive care plan, dated 02/21/25, reflected Resident #9 used anti-anxiety medications related to anxiety disorder. Interventions included: Educate the residents/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of anti-anxiety medication drugs being given. Record review of Resident #9's Physicians Order Summary Report for the month of December 2025 reflected an order for Ativan (an antianxiety medication) one tablet by mouth two times daily for anxiety dated 06/17/2025. Record review of Resident #9's quarterly MDS assessment, dated 12/08/2025, reflected she was admitted on [DATE]. Her diagnoses included respiratory failure, atrial fibrillation (irregular heart rate), and hypertension (elevated blood pressure). Resident #9 was coded as being dependent on staff for shower/bathing. Resident #9 had a BIMS score of 02, which indicated severe cognitive impairment. Record review of Resident #9's electronic medical records for dates of 02/08/2024 thru 12/19/2025 reflected there was no informed consent for Ativan on file. In an observation and interview on 12/16/2025 at 10:30 a.m., Resident #9 stated she had no complaints related to care. Resident #9 appeared clean with her hair combed and was dressed appropriate for the weather. In an interview on 12/19/2025 at 1:15 p.m., LVN O stated, I don't think we have to do a consent for Ativan routine only as needed. She stated staff normally obtain consents for Ativan. She stated she was not sure where the Ativan consent was located at this time. LVN O stated the nurse who received the order for medication requiring a consent was responsible for obtaining it at the time the order was received. She stated if consent were not obtained the family would not be aware of side effects. In an interview on 12/19/25 at 1:30 p.m. ADON L stated the nurse who took the orders for any medication requiring informed consent, should obtain consent at that time. She stated the assistant directors were responsible for reviewing orders and ensuring consents were in the electronic medical record. ADON L stated the purpose of the consent was to ensure residents or responsible parties were informed related to purpose and side effects of the medication. The negative effects for not obtaining consent for anxiety medications would be that the resident/family may not be aware of side effects. Record review of facility policy dated 2001 titled Residents Rights reflected: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to be notified of his or her medical condition and of any changes in his or her condition be informed of and participate in, his or her care planning and treatment.		

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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 observation, interview, and record review, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodations of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 6 residents (Resident #65) reviewed for resident rights. The facility failed to ensure Residents #65's call light was within reach on 12/16/2025. This failure could place residents at risk of their needs not being met. Findings include: Record review of Resident #65's admission record, dated 12/19/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. Resident #65 had diagnoses which included: Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills), contracture right and left shoulder (permanent tightening and stiffing of muscles, tendons, skin, or other tissue causing joints or body parts to shorten and become fixed in a bent or awkward position), anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), and pain (unpleasant feeling like sting, ache, or burn, that tells your brain something is wrong, like an injury or potential harm). Record review of Resident #65's Quarterly MDS assessment, dated 09/29/2025, reflected Resident #65 had a BIMS score of 03, which indicated severe cognitive impairment. Resident #65 required substantial/maximal assistance in the areas of shower/bathe self, upper body dressing, and personal hygiene. Resident #65 was dependent on staff in the areas of toileting hygiene, lower dressing, putting on/taking off footwear and personal hygiene. Record review of Resident #65's care plan, dated 12/19/2025, reflected high risk for fall r/t confusion, impaired balance, Vitamin D Deficiency, history of falling presence of left artificial hip joint unequal limb length, hyponatremia (salt level in your blood become abnormally low) Resident #65 had an intervention of be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. During an observation on 12/16/2025 at 09:59 a.m., Resident #65's call light was observed hanging towards the floor at the foot of her bed while Resident #65 sat in a Geri chair approximately three feet from where her call light was placed. Resident #65 could not be interviewed due to her cognitive status. During an interview with CNA B on 12/19/2025 at 12:20 p.m., CNA B stated she was assigned the D hall were Resident #65 resided. CNA B stated that it was everyone's responsibility to ensure call lights were always within reach. CNA B stated if a resident's call light was not within reach, then the resident would not be able to call for assistance. During an interview on 12/19/2025 at 12:45 p.m., the ADON stated it was everyone's responsibility to ensure resident call lights were within reach at all times. ADON stated that CNAs make round at least every two hours or as needed. The ADON stated during rounds CNAs should look to see if a resident's call light was within reach. The ADON stated if a resident call light was not within reach, then the resident would not be about to call for assistance if needed. During an interview on 12/19/2025 at 1:20 p.m., the ADM stated call lights should always be within reach. The ADM stated it was everyone's responsibility to ensure the call lights were within reach. The ADM stated if a resident's call light was not within reach, then the resident would not be able to express their needs nor have their needs met. The ADM stated her expectation was for staff members to ensure call lights were within reach prior to existing the resident's rooms. A record review of the facility's Resident Call System policy, October 2022, reflected 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 4. If a resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 3 of 6 residents (Resident #3, Resident #6, and Resident #84) who were reviewed for accuracy of assessments. 1. Resident #3's SCSA MDS did not indicate he was admitted to hospice in all the necessary sections. 2. Resident #6's most recent comprehensive MDS was coded as having a catheter, but Resident #6 did not have an order for a catheter, nor was he observed with one. 3. Resident #84's most recent comprehensive MDS was coded as resident having used insulin in the last 7 days, when medication review, orders, and interviews revealed that Resident #84 did not use insulin. This failure placed residents at risk of incorrect care and services necessary for their physical, mental, and psychosocial well-being. Findings included: Review of Resident #6's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: high blood pressure, arthritis (painful inflammation and stiffness of the joints), Non-Alzheimer's dementia (memory impairment and challenges in performing daily activities), anxiety (feelings of worry, nervousness, or unease), Post-Traumatic Stress Disorder (mental health condition that arises after experiencing or witnessing and extremely stressful or terrifying event). In section H - Bladder and Bowel, Resident #6 had a ?x' in box ?A. Indwelling catheter (including suprapubic catheter and nephrostomy tube)'. In section V - Care Area Assessment (CAA) Summary, under care area 06. Urinary Incontinence and Indwelling Catheter, there were ?x's in box ?A. Care Area Triggered' and box ?B. Care Planning Decision' Resident #6 had a BIMS score of 01, indicating severely impaired cognition. Review of Resident #6's comprehensive care plan dated 11/19/2025 reflected no interventions for catheter usage, monitoring, or output documentation needed. Review of Resident #6's active doctor's orders as of 12/17/2025 reflected no orders for a catheter. Review of Resident #84's quarterly MDS dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: anemia (deficiency of red blood cells), high blood pressure, diabetes mellitus (a disease in which the body's ability to produce or respond to insulin is impaired, resulting in abnormal metabolism and elevated glucose levels). In section N - Medications, under the Insulin category, MDS S indicated Resident #84 had been administered insulin 7 days out of the last 7 days. Resident #84 had a BIMS score of 09, indicating moderately impaired cognition. Review of Resident #84's comprehensive care plan dated 12/03/2025 reflected no interventions for insulin usage. Review of Resident #84's active doctor's orders as of 12/19/2025 dating back to November 20, 2025, reflected no orders for an insulin injection medication. In an observation on 12/16/2025 at 10:29 AM, Resident #6 was observed standing in the secured unit hallway, and no catheter collection bag was observed on his person. In an interview on 12/19/2025 at 11:49 AM with LPN G, she stated that she had never administered insulin to Resident #84 since she began working at the facility in October 2025. She stated that Resident #84 had low blood sugar, and he got finger sticks daily, but Resident #84 also had ESRD, and certain diabetes medications could cause a buildup of lactic acid enzymes. She stated that Resident #6 was not admitted to the facility with a catheter, but that he was admitted on hospice and was very thin at the time. In an interview on 12/19/2025 at 12:05 PM with MDS S, she stated that she was responsible for conducting MDS assessments and that she had completed Resident #84's MDS assessment. She stated that at one time Resident #84 may have taken insulin, but the coding was an error, and she would correct it. She also stated that indicating Resident #6 had a catheter was an error, and she would need to correct it. She stated that inaccurate assessments could lead to inadequate care because assessments helped direct care staff know what care to provide. In an interview on 12/19/2025 at 12:26 PM with MDS D, she stated that Resident #3 admitted to hospice on 9/13/2024 and that the SCSA not having Hospice indicated was just missed in section J, but it was listed in section O as having a life expectancy less than 6 months. In an interview on 12/19/2025 at 1:09 PM (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the ADM, she stated that her expectation for MDS accuracy was for them to be done correctly and accurately. She stated that they have a regional specialist who oversaw MDS work . Review of the facility's MDS Coding Policy dated 06/02/2025 reflected, [Company] affiliated facilities utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident Assessment, timely and accurately.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for 1 of 6 residents (Resident #73) reviewed for PASARR Level I screenings. The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #73. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis (Major Depressive Disorder) was present upon Resident #73's admission date on 01/17/2025. This failure could place residents at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs. Findings included: Record review of Resident #73's face sheet, dated 12/19/2025, reflected a [AGE] year-old male, admitted on [DATE]. Resident #73 had diagnoses which included: major depressive disorder (serious mood disorder causing persistent sadness, hopelessness, and loss of interest in activities, significantly impacting daily life), type 2 diabetes mellitus (when the body cannot use insulin correctly and sugar builds up in the blood), anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), and chronic pain syndrome (when pains lasts over 3-6 months). Record review of Resident #73's Quarterly MDS assessment, dated 11/28/2025, reflected Resident #73 had a BIMS score of 12, which indicated moderate cognitive impairment. Resident #73's Quarterly MDS also reflected Resident #73 had an active diagnosis of major depressive disorder. Record review of Resident #73's PASRR Level 1 Screening, dated 01/13/2025, reflected that Section C Mental Illness was marked as no, which indicated Resident #73 did not have a mental illness. Record review of Resident #73's care plan, dated 12/19/2025, reflected Resident #73 was care planned for depression r/t Disease Process Major Depressive disorder and the resident uses antidepressant medication (Duloxetine) r/t Depression. Record review of Resident #73's admission notes, dated 01/14/2025, reflected Resident #73 had a diagnosis of major depressive disorder. During an interview on 12/19/2025 at 10:10 a.m., MDS D stated Resident #73 had a diagnosis of major depressive disorder and does not have a diagnosis dementia. MDS D stated Resident #73 should have had a PASSR Level 2 assessment completed due to his diagnosis of major depressive disorder. MDS D stated a negative outcome would be Resident #73 would not receive the proper services he needed. During an interview on 12/19/2025 at 1:20 p.m., the ADM stated it was the MDS Coordinator's responsibility to ensure the PASRR level 1 was completed accurately. The ADM stated that Resident #73 should have received a PASSR Level 2 assessment due to his diagnosis of major depressive disorder. The ADM stated a negative outcome would be Resident #73 would not receive the proper services he needed. Record review of the facility's policy, Preadmission Screening and Resident Review (PASRR) revised 07/18/18 reflected: Health-related Quality of Life Individuals who have or are suspected to have MI, ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the state. Planning of Care The Level II PASRR determination and the evaluation report specify services to be provided by the nursing home and/or specialized services defined by the state. The services to be provided by the nursing home and/or specialized services provided by the State that are specified in the Level II PASRR determination and the evaluation report should be addressed in the plan of care .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews , and record review the facility failed to develop a comprehensive person-centered care plan furnishing services to attain, or maintain, the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #6) reviewed for comprehensive care plans. The facility failed to care plan Resident #6's PTSD and/or triggers. This failure could place residents at risk of their needs going unmet. Findings included: Review of Resident #6's comprehensive MDS dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: high blood pressure, arthritis (painful inflammation and stiffness of the joints), Non-Alzheimer's dementia (memory impairment and challenges in performing daily activities), anxiety (feelings of worry, nervousness, or unease), Post-Traumatic Stress Disorder (mental health condition that arises after experiencing or witnessing and extremely stressful or terrifying event). Resident #6 had a BIMS score of 01, indicating severely impaired cognition. Review of Resident #6's comprehensive care plan dated 11/19/2025 reflected he had not been care planned for his PTSD and identified triggers were not listed. Review of Resident #6's social history assessment dated [DATE] and conducted by the facility SW, reflected a history of PTSD. In section G - Trauma Informed Care, Resident #6 was indicated as having a history of trauma, a diagnosis of PTSD, and triggers that caused emotional distress related to the condition were: loud noises such as banging doors/booming music, alarms. His occupational history reflected that he had been an infantry in the army. In an interview on 12/19/2025 at 12:26 PM with MDS D, she stated that a trauma assessment was something that the SW was responsible for, but the SW was out on leave. The MDS D stated she conducted a Trauma Informed Assessment on 12/17/2025 for Resident #6 after the surveyor brought it to the attention of the facility. She stated that the care plan was a team effort, and she added the triggers to Resident #6's care plan after she conducted the assessment. In an interview on 12/19/2025 at 1:09 PM with the ADM, she stated that the facility used a trauma informed evaluation upon admission, and she expected care plan meetings to be held with families to receive their input about things residents could not vocalize. She stated that sometimes the secured unit would get a little loud, but that she did not change the staff that work back there to help with routine. Review of the facility's policy titled 'Care Plans, Comprehensive Person-Centered' dated 6/02/2025 reflected, The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 8. The comprehensive, person-centered care plan will: Incorporate identified problem areas; Incorporate risk factors associated with identified problems Review of the facility's policy titled 'Trauma-Informed and Culturally Competent Care' dated 6/17/2025 reflected, Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for 1 of 6 residents (Resident #32) reviewed for quality of life. The facility failed to ensure Resident #32's nails were cleaned and trimmed. This failure could place residents at risk for poor hygiene, dignity issues, and decreased quality of life Findings included: Record review of Resident #32's admission record, dated 12/19/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #32 had diagnoses which included: Rett syndrome (a rare genetic neurological disorder mostly in girls that cause problems with movement, communication, and often having autistic like behavior and seizure), myopia (eye condition where closer objects appear clear but distant objects look blurry), and conversion disorder with seizure or convulsion (a disorder that affects the way your brain sends, receives and processes messages). Record review of Resident #32's Annual MDS assessment, dated 10/10/2025, reflected Resident #32 had a BIMS score of 00, which indicated severe cognitive impairment. Resident #32 was dependent on staff in the areas of eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Record review of Resident #32's care plan, dated 12/19/2025, reflected Resident #32 was care planned for ADL self-care performance deficit r/t Disease Process Rett's syndrome, Scoliosis, other acquitted deformities of right foot, profound ID, and muscle weakness. Resident #32 had intervention of PERSONAL HYGIENE/ORAL CARE: the resident is extensive assist on 1 staff for personal hygiene and oral care. During an observation on 12/16/2025 at 12:13 p.m., Resident #32's fingernails on her left hand were dirty and untrimmed. During an observation on 12/17/2025 at 2:01 p.m.PM, Resident #32's fingernails on her left hand were dirty and untrimmed. Resident #32 could not be interviewed due to her cognitive status. During an interview with CNA B on 12/19/2025 at 12:20 PM, CNA B stated any CNA could provide nail care if the resident was not diabetic. CNA B stated that Resident #32 was not diabetic. CNA B stated nail care was usually provided on the resident's shower days or as needed. CNA B stated Resident 32 shower days were Monday, Wednesday and Friday. CNA B stated if nail care is not provided as needed then the residents would have dirty nails or could possibly get sick from putting their dirty nails in their mouth. During an interview on 12/19/2025 at 12:45 PM, the ADON stated Resident #32 was not diabetic so any CNA could have provided nail care for her. The ADON stated that nail care should be provided as needed and on the resident's shower day. The ADON stated if residents' nails were not cleaned then the residents were at risks of infections. During an interview on 12/19/2025 at 1:20 PM, the ADM stated that CNAs should provide nail care as needed or during the resident's shower day if the resident is not diabetic. The ADM stated if a resident's nail care was not provided then the resident would be at risk for infections or possibly scratch themselves if their nails were not trimmed. The ADM stated her expectation was that resident's nail care be provided as needed or during the resident's shower day. A record review of the facility's Activities of Daily Living (ADL), Supporting policy, revised dated April 2025, reflected Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Policy Interpretation and Implementation 1. Residents are provided with care, treatment, and services to ensure their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition (s) demonstrate diminishing ADLs are unavoidable. 5. Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with consent of the resident, and in accordance with the plan of care, including appropriate support with assistance with: a. hygiene (bathing, dressing, grooming, and oral care) .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 6 residents (Resident #36) reviewed for accidents and supervision. 1. The facility failed to ensure Resident #36 did not leave the facility without nursing staff being aware and he was found by state survey staff in front of a store approximately 100 yards from the facility. 2. The facility failed to follow their elopement policy when informed of a missing resident. These failures placed residents at risk of elopement, falls, or other accidents. Findings included: Review of Resident #36's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: anemia (deficiency of red blood cells), Schizophrenia (mental disorder characterized by hallucinations, delusions, disorganized thinking or behavior), acquired absence of unspecified leg below knee (amputation), and diabetes mellitus (a disease in which the body's ability to produce or respond to insulin is impaired, resulting in abnormal metabolism and elevated glucose levels). His BIMS score was 14, indicating intact cognition. Review of Resident #36's comprehensive care plan dated 12/04/2024 reflected 11/7/2024 I am able to sign myself out and smoke independently outside. Resident refuses to wear a smoke apron during smoking. Resident noted to go to [store] and smoke in the front of the store. He was care planned for being at high risk of falls, refusing labs and immunizations, and being non-complaint with his diet pertaining to his diagnoses of diabetes. Review of resident sign out sheet revealed Resident #36 did not sign himself out on 12/19/2025. In an observation on 12/19/2025 at 8:28 AM, Resident #36 was observed to be maneuvering in a manual wheelchair in a store parking lot located approximately 100 yards to the right of the facility. He parked himself to the left side of the store's front door. In an interview on 12/19/2025 at 8:34 AM with LPN K, he stated that residents were able to go outside, but they were not allowed to leave the premises unless they had signed out. He stated there was a policy regarding residents signing out when they left the facility, and that residents knew they were supposed to sign out if they left the premises. He stated in order to account for the number of residents in the building, staff completed a head count at the beginning of their shift. He stated he did not know if there was a policy on missing residents. In an interview on 12/19/2025 at 8:40 AM with LVN C, she stated that Resident #36 would go in his wheelchair around the facility, smoke outside, and go to the store often. She stated Resident #36 was not in his room at the time of this interview, and Resident #36 had not informed her of his whereabouts. She stated Resident #36 may be somewhere around the facility at the time, or at the store that he frequently visited. In an interview on 12/19/2025 at 8:51 AM with the ADON, she stated that residents were able to go outside but they had to sign out if they left the premises. She stated there was a policy regarding residents signing out if they left the facility. She also stated there may be a policy on missing residents but had to look for it. In an additional interview on 12/19/2025 at 9:23 AM with the ADON, she stated that Resident #36 had returned to the facility, but that he had returned on his own, and staff had not gone to retrieve him. She stated he normally went to the store to smoke and sometimes stayed so long that the store would call the police and file a charge of criminal trespassing to get him to return to the facility. She stated he went to the store all the time and that they had educated him in the past on signing out before he went to the store. She stated there were no additional interventions in place to ensure residents signed out before they left the facility. She stated that 6 residents with high BIMS scores and low wandering risk assessment scores had the facility front door code, and Resident #36 was one of them. In an interview/observation on 12/19/2025 at 9:50 AM with Resident #36, he stated that he was at the store buying smoking materials. He stated that he let himself out of the door with the code and he forgot to sign out because he could not find the binder. He stated the binder was kept at the nurse's (continued on next page)		

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	station. He was observed to have a manual wheelchair and was hard of hearing, having to turn his head so that his left ear was facing the surveyor. He stated he must get on the side of the road to get to the store. He stated he did not recall being educated by staff on the purpose of using the sign out book. In an interview on 12/19/2025 at 9:57 AM with LVN C, she stated that she went to the store and got Resident #36 to go back to the facility. She stated she started walking around the building and saw Resident #36 at the store. She stated that they had educated him before on signing out before leaving. She stated that he could have fallen, and that he used the side of the road to get to the store. She stated that he usually signed himself out but sometimes forgot. She stated he usually stayed at the store until he decided to go back to the facility. She stated in the past when he did not go back in a reasonable time, she would just lay eyes on him through a facility window and not go get him. In an interview on 12/19/2025 at 1:12 PM with Resident #36's PCP, he stated that Resident #36 went to the store quite often and had some underlying psychiatric issues. The PCP stated that the facility has had discussions with Resident #36, but he was not compliant, such as with drawing labs. He stated there was some concern with Resident #36's checking himself out and causing a [NAME] with the neighboring business's customers. He stated that for Resident #36's safety, he felt that Resident #36 needed to be signing out with his family. Review of the facility's policy titled, Wanderer Management, Monitoring System & Resident Elopement Protocol dated 5/2025 reflected, It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. Missing resident shall be defined as a resident who has left the facility grounds without signing him/herself out.F. Procedure for Missing residents/ Elopement:I. If a resident is noted to be missing, the following must be initiated immediately: Notify the Administrator/designee immediately. Perform a complete search of the interior of the building. This should include every room, including bathrooms, break rooms, storage rooms, closets, etc. Initiate an external search outside of the building, including the facility grounds and community, on foot and by vehicle.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for the residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 (Resident #6) of 6 residents reviewed for trauma-informed care. The facility failed to ensure Resident #6 had a trauma assessment completed upon admission to the facility that identified possible triggers when Resident #6 admitted with a diagnosis of PTSD. This failure could place residents at an increased risk of psychological distress due to re-traumatization. Findings included: Record review of Resident #6's comprehensive MDS, dated [DATE], reflected a [AGE] year-old male admitted on [DATE] with the following diagnoses: high blood pressure, arthritis (painful inflammation and stiffness of the joints), Non-Alzheimer's dementia (memory impairment and challenges in performing daily activities), anxiety (feelings of worry, nervousness, or unease), Post-Traumatic Stress Disorder (mental health condition that arises after experiencing or witnessing and extremely stressful or terrifying event). Resident #6 had a BIMS score of 01, indicating severely impaired cognition. Record review of Resident #6's comprehensive care plan, dated 11/19/2025, reflected he was not care planned for PTSD and identified triggers were not listed. Record review of Resident #6's social history assessment, dated 10/21/2025 and conducted by the facility SW, reflected a history of PTSD. In section G - Trauma Informed Care, Resident #6 was indicated as having a history of trauma, a diagnosis of PTSD, and triggers that caused emotional distress related to the condition were: loud noises such as banging doors/booming music, alarms. His occupational history reflected that he had been an infantry (ground combat/to fight on foot) in the army. In an observation on 12/16/2025 at 10:29 AM, Resident #6 was observed standing in the secured unit hallway, when the surveyor attempted to interview him, he just stared blankly and did not answer questions. He was determined to be non-interviewable due to cognitive impairments. In an interview on 12/19/2025 at 12:26 p.m. MDS D, stated a trauma assessment was something the SW was responsible for, but the SW was not at work. MDS D stated she conducted a Trauma Informed Assessment on 12/17/2025 for Resident #6 after the surveyor brought it to the attention of the facility. She stated the care plan was a team effort, and MDS D added the triggers to Resident #6's care plan after MDS D conducted the assessment. She stated triggers were important to document to help residents feel safe. In an interview on 12/19/2025 at 1:09 p.m., the ADM stated the facility used a trauma informed evaluation upon admission, and she expected care plan meetings to be held with families to receive their input about things residents could not vocalize. She stated that sometimes the secured unit was a little loud, but she did not change the staff that worked there to help with routine. Review of the facility's policy titled 'Trauma-Informed and Culturally Competent Care' dated 6/17/2025 reflected, Organizational Strategies3. Select screening and assessment tools in collaboration with the QAPI Committee. (See Trauma-Informed Care Screening and Assessment Toolkit for further resources)Resident Screening1. Perform universal screening of residents, which includes a brief, non-specialized identification of possible exposure to traumatic events.2. Utilize screening tools and methods that are facility-approved, competently delivered, culturally relevant and sensitive.Resident Assessment1. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers.2. Utilize licensed and trained clinicians who have been designated by the facility to conduct trauma assessments.Resident Care PlanningDevelop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received the necessary behavioral health care and services to attain or maintain the highest practicable mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for 1 of 6 residents (Resident #13) whose records were reviewed for behavioral health services. The facility failed to provide psychological services for Resident #13 to treat her symptoms of depression noted by her recent behaviors and MDS assessment. This deficient practice could place residents with documented signs of depression at risk of increased decline in the psychosocial well-being and diminished quality of life. Findings included. Review of Resident #13's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included chronic kidney disease stage 5, muscle weakness, low thyroid hormone, and insomnia. Resident #13 was coded as being dependent on staff for shower/bathing. Resident #13 had a BIMS score of 12, which indicated moderate cognitive impairment. The MDS indicated Resident #13 was feeling down, depressed, or hopeless 7-11 days out of 14 within the last 2 weeks. Review of Resident #13's comprehensive care plan dated 09/26/25 revealed Resident #13 had chronic renal failure related to kidney disease stage 5, interventions included Monitor/document/report as needed any signs or symptoms of depression. Obtain order for mental health consult if needed. Record review of Resident #13's Physicians Order Summary Report reflected she was not on any medications to assist with depression symptoms and had no order for any counselling or psychiatric services. Record review of Progress notes dated 12/13/25 reflected Resident returned from dialysis after leaving AMA. Dialysis facility verbalized she was emotionally upset signed by LVN P. In an attempted interview and observation on 12/17/2025 11:44 a.m. Resident #13 was sitting up in her wheelchair in her room with her head looking down and declining to engage with surveyor. In an interview on 12/19/2025 at 1:24 pm LVN O stated she did feel like Resident #13 was depressed but had not been evaluated for psychiatric services. She stated she would notify the DON and primary doctor if a resident may need behavioral health services. LVN O stated the doctor was aware of Resident #13 behaviors of frequently refusing care. She stated the nurses are responsible for making the DON aware of need for services. She stated the importance of providing services was so residents could cope with ongoing medical issues, LVN O stated she had not notified the DON of her concerns for Resident #13's depression. In an interview on 12/19/25 at 1:30 p.m. ADON L stated the DON sets up mental health services for residents showing symptoms of depression. She stated the nurses would report to the doctor if there were some types of depression symptoms and obtain an order for psychiatric services or counselling. ADON L stated she was not sure if the facility provided counselling services, she thinks there is someone who does come but was not sure if they are counselling services or what they do. She stated the negative effects of not providing some sort of psych services could be decreased quality of life, and increased depression. Record review of facility policy dated 06/02/2025 titled Behavioral Health Services reflected: The facility will provide necessary behavioral health care and services which include: Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety that meets the needs of residents with mental disorders, substance use disorders, a history of past trauma, and other behavioral health needs and Provide care, in accordance with the individualized care plan.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services in that: The facility's dietary staff failed to discard an outdated item in the walk-in freezer. This failure could place residents at risk for food contamination and foodborne illness. The findings include: During a tour of the kitchen on 12/16/2025 at 09:00 AM the following was observed: The freezer contained an item labeled Tulip Greens with Butter in a clear plastic bag with a use by date of 11/10/2025. During an interview with DM on 12/18/2025 at 1:10 PM, DM stated that the cooks were responsible for ensuring that items were discarded by the used by date. DM stated that the item labeled Tulip Greens with Butter should have been used by or discarded by the 11/10/2025 as dated on the bag. DM stated that if an item was not used by or discarded by the used by date then that item could get cause residents to get sick. DM stated her expectation was for all items to be used or discarded by their used by date. During an interview with the [NAME] on 12/18/2025 at 1:15 PM, the [NAME] stated all kitchen staff were responsible for discarding items if their used by day had passed. The [NAME] stated that if an item's used by date had passed and the item was served, the resident could get sick. During an interview with the ADM on 12/19/2025 at 1:20 PM, the ADM stated all items passed the used by date should be thrown away immediately. The ADM stated that the kitchen staff should monitor the refrigerator and freezer daily for items that are outdated. The ADM stated that outdated items could cause residents to get sick if served. Record review of the facility's Food Receiving and Storage policy, revised dated 06/23/25, reflected: Policy Statement Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 2 of 6 residents reviewed for infection control (Resident #5, and Resident #70). 1) LVN C did not wash her hands when removing soiled gloves, prior to applying clean gloves on 12/17/2025 at 10:01 a.m. for Resident #5's wound care observation. 2) CNA M and CNA N failed to clean their hands prior to the start of and after changing gloves when moving from a dirty to clean site while performing peri care for Resident #70 on 12/17/2025 at 11:04 a.m. This failure could place residents at risk for cross contamination and the spread of infection. Findings included: 1. Record review of Resident #5's care plan, dated 10/21/2024, reflected, Resident #5 had a pressure area to mycoccyx related to immobility and I (Resident #5) have actual impairment to my skin integrity on the right outer ankle. Interventions included: Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to medical doctor. Record review of Resident #5's Quarterly MDS, dated [DATE], reflected an admission date of 04/11/2023 with diagnoses of peripheral vascular disease (a circulation problem blocking blood flow to the lower extremities), hypertension (elevated blood pressure), and diabetes mellitus (elevated blood sugar). Resident #5 had a BIMS score of 12 indicating moderate cognitive impairment. Resident #5 required a wheelchair for mobility, substantial/maximal assistance for personal hygiene and was dependent for lower body dressing. The MDS reflected Resident #5 had one or more unhealed pressure ulcers and required an application of nonsurgical wound dressings (other than the feet) and an application of a wound dressing to the feet. Record review of Resident #5's Physicians Order Summary, dated 12/18/2025, reflected an order to cleanse wound to coccyx with wound cleanser, pat dry, spray with skin prep, apply collagen to the wound bed, cover and secure with bordered dressing every Monday, Wednesday, and Friday and cleanse wound to right outer ankle with wound cleanser, pat dry, cover with collagen dressing (a type of wound dressing applied to promote cell growth and healing) to wound bed and secure with bordered gauze dressing every Monday, Wednesday and Friday. In an interview and observation on 12/17/2025 at 10:01 a.m. Resident #5 was lying in bed alert and stated he was feeling ok. He denied any pain. LVN C removed soiled dressing from coccyx (buttocks) and discarded it, removed her soiled gloves and applied clean gloves failing to cleanse hand prior to the application of clean gloves. LVN C proceeded with finishing wound care and covered Resident #5 up giving him his call light. In an interview on 12/17/2025 at 10:30 a.m., LVN C stated she was educated on infection control. LVN C stated she had forgotten to wash her hands in between glove changes. LVN C stated the risk or negative impact for not washing hands between clean and dirty was spreading germs and infection. 2. Record review of Resident #70's Quarterly MDS, dated [DATE], reflected an admission date of 05/22/2023 with diagnoses of hypertension (elevated blood pressure), diabetes mellitus (elevated blood sugar) and non-Alzheimer's dementia (impaired memory and cognition effecting daily routine). Resident #70 had a BIMS score of 3 indicating severe cognitive impairment. Resident #70 required a wheelchair for mobility, had upper and lower body mobility impairment, and was dependent on staff for personal hygiene. The MDS reflected Resident #70 was always incontinent of bowel and bladder. In an observation and interview on 12/17/2025 at 11:04 a.m. Resident #70 was lying in bed and gave permission for peri care. CNA M and CNA N proceeded to prepare to provide peri care to Resident #70. CNA M and CNA N did not wash or clean hands with Alcohol based hand sanitizer prior to applying gloves and starting peri care. They proceeded with care and removed soiled brief from Resident #70. CNA M and CNA N changed their gloves and did not wash their hands between changing of gloves. They both completed peri care for Resident #70, disposed of soiled brief, and washed their hands with soap and water. In an interview on 12/17/2025 at 11:44 a.m., CNA M and CNA N stated they forgot to change gloves and wash their hands or use alcohol-based hand sanitizer when changing (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 12/19/2025
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their gloves. They stated generally it was routine for them to clean their hands between gloving and prior to the start of resident care. They stated they were nervous and forgot. They stated they were trained on infection control by the ADON. They stated not washing their hands could spread germs causing infections. In an interview on 12/19/25 at 1:30 p.m., ADON L stated it was her expectation that hand sanitizer was used in-between gloving, going from dirty to clean gloves. ADON L stated the staff were educated on infection control. ADON L stated the nursing administrative staff completed in-services and monitored infection control practices throughout the facility by making frequent nursing rounds and checking on the residents. ADON L stated there was not one administrative nurse specifically responsible for education, Record review of facility policy titled Handwashing-Hand Hygiene Policy and Procedures, dated March 2020 and revised October 2020, reflected hand hygiene was indicated before handling clean or soiled dressings/gauze pads, moving from work on a soiled body site to a clean body site on the same resident and after glove removal.		