

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Willow Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 Whippoorwill Kilgore, TX 75662	

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)
<p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339</p> <p>Based on record review, and interview, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility for 2 of 5 residents (Resident #1 and Resident #2) reviewed for discharge rights, in that:</p> <p>The facility failed to ensure Resident #1 had a safe and orderly discharge to a home environment on 9/12/2024. Resident #1 was discharged from the facility with no place to go and made to sit outside and found approximately 7 hours later on the ground behind the facility and transported to the hospital with A-fib and high blood pressure.</p> <p>The facility failed to ensure Resident #2 had a safe and orderly discharge to a home environment on 11/14/2024. Resident #2 who needed supervision and assistance with some ADL's and was a moderate fall risk was discharged to a motel and had multiple falls.</p> <p>The failures resulted in the identification of an Immediate Jeopardy (IJ) on 12/10/2024 at 4:28 p.m . The IJ template was provided to the facility on [DATE] at 4:28 p.m. While the IJ was removed on 12/12/2024 at 4:15 p.m., the facility remained out of compliance at a level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy with a scope identified as pattern until interventions were put in place to ensure residents were discharged safely.</p> <p>The failures could place residents at risk of being discharged without preparation, causing a disruption in their care and services and denying them a voice regarding their treatment plan.</p> <p>The findings were :</p> <p>1.Record review of Resident #1's face sheet, dated 12/9/2024, indicated Resident #1 was a [AGE] year old male that admitted to the facility on [DATE] with his most recent admission on 8/8/2024 with diagnoses of hemiplegia and hemiparesis following cerebrovascular (blood flow to the brain) disease affecting left non-dominant side (weakness on the left side of the body), type 2 diabetes mellitus with diabetic neuropathy (high blood sugar with nerve damage), and unspecified symptoms and signs involving the nervous system.</p> <p>Record review of Resident #1's quarterly MDS, dated [DATE], revealed the following:</p> <p>-C0500. BIMS Summary Score= 14 signifying no cognitive impairment.</p> <p>(continued on next page)</p>

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 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>- G0170. A. Roll left and right - The ability to roll from lying on back to left and right side and return to lying on back on the bed. The answer was, Independent.</p> <p>- G0170. B. Sit to lying - The ability to move from sitting on side of bed to lying flat on the bed. The answer was, Supervision or touching assistance.</p> <p>- G0170. C. Lying to sitting on side of bed - The ability to move from lying on the back to sitting on the side of the bed and with no back support. The answer was, Supervision or touching assistance.</p> <p>- G0170. D. Sit to Stand - The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. The was Independent.</p> <p>- G0170. E. Chair/bed-to-to-chair transfer - The ability to transfer to and from a bed to chair (or wheelchair). The answer was, Supervision or touching assistance.</p> <p>- G0170. F. Toilet transfer - The ability to get on and off a toilet or commode. The answer was, Supervision or touching assistance.</p> <p>- G0170. FF. Tub/shower transfer - The ability to get in and out of a tub/shower. The answer was, Supervision or touching assistance.</p> <p>- Q0400: Discharge Plan A. Is active discharge planning already occurring for the resident to return to the community? The answer for this item was No.</p> <p>Record review of Resident #1's care plan dated 10/26/2022 and revised on 9/17/2024 indicated: Resident had an ADL self-care performance deficit and was at risk for not having their needs met in a timely manner with interventions that included: Bed Mobility: Limited assistance., Transfers: Usually independent but may need limited assistance at times., Toileting: Limited assistance, Ambulation: Ambulates only with therapy and needs extensive assistance, Wheelchair: Independent with an electric scooter, Dressing: Extensive assistance, Bathing: Extensive assistance.</p> <p>Record review of Resident #1's psychological services note dated 8/20/2024 indicated Resident #1 was seen by psychiatric services due to displayed symptoms such as adjustment difficulty, agitation, aggressive behaviors, anger and depression. Patient risk of aggression is at risk for verbal aggression Pt has a history of verbal aggression but none was noted in this session.</p> <p>Record review of Resident #1's psychological services note dated 9/4/2024 indicated Resident #1 was seen by psychiatric services due to displayed symptoms such as adjustment difficulty, agitation, aggressive behaviors, anger and depression. Patient risk of aggression is at risk for verbal aggression Pt has a history of verbal aggression but none was noted in this session.</p> <p>Record review of Physician/NP/PA Progress Note-V3 dated 9/11/2024 indicated: 8. Musculoskeletal: c. Unstable gait. 3. Concern for a condition or chronic disease that may result in a life expectancy less than 6 months a. Yes.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's hospital records dated 9/13/2024 at 12:30 AM indicated Resident #1 [AGE] year old male resident of the nursing home for over a year patient said that he is here because the nurse said that he had atrial (two upper chambers of the heart) for he has known atrial Fib (irregular beating of the heart in the two upper chambers) he is a cardiac defibrillator apparently the patient got into some type of conflict with people at the nursing home over some pain medication he somehow used a scooter when outside and then was told he was not allowed to return inside so he laid down outside rest or sleep and then was unable to get up because of chronic left-sided paralysis from a stroke and generalized weakness nurse came out and examined him and said he had A-fib and called EMS and he was transported patient reported that he has been nauseated with vomiting yesterday had some diarrhea yesterday not having any specific pain especially not chest pain and vomited today patient reports that he is into hospice care past history includes COPD stroke diabetes CHF CABG hypertension MI peripheral vascular disease . Pt arrived via EMS with c/o fatigue, headache, and nausea. Pt reported that he was kicked out of the nursing home today after a verbal altercation with staff. Pt reported that he was laying on a bench outside when he began feeling weak. Pt reported hx of stroke and now has left sided arm and leg weakness for that.]sic] Resident #1 had lab work performed at the hospital which indicated Resident #1's glucose was high at 154 (normal 74-118), his BUN (blood urea nitrogen) level was high at 22 (normal 6-20), his potassium level was low at 2.8 (normal 3.6-5.1), his chloride level was low at 99 (normal 101-111). Resident #1's chest x-ray indicated Mild pulmonary edema (swelling) and small left pleural effusion (accumulation of fluid between the lungs and chest wall).</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/10/2024 at 9:59 AM Hospice RN C said she had seen Resident #1 the day before he was discharged and the facility wanted a recommendation to go to a behavioral hospital. She said she did not agree with a behavioral hospital, and they would make medication changes. She said on 9/12/2024 she received a call from ADON B that they were kicking Resident #1 out and she went to the facility and the resident was sitting outside and the facility would not let him back in. She said she went into the facility and talked to the Administrator, ADON A, and ADON B and they said he had threatened to run over a nurse. She said they told her they had asked for a behavioral hospital referral, and they would not agree. She said Resident #1 had gotten out of bed and asked for pain medication and the nurse was arguing with Resident #1 about his pain medication. She said she spoke with Resident #1, and he told her yes, he had threatened to run over the nurse, but it was out of anger, and he didn't mean it. She said Resident #1 had some vulgar language but felt like the staff was provoking him. She said Resident #1 told her he just wanted to smoke, and the facility told him if he went out the door, they would not let him back in. She said the facility Administrator said they had called the Ombudsman and she said yes kick him out. She said the facility put all his belongings in 3 trash bags and put them outside with him. She said the facility told her Resident #1 was not allowed to go back in the facility. She said she sat outside with Resident #1 and tried calling to find Resident #1 emergency placement. She said she then talked to the Administrator again to ask for Resident #1 to stay at the facility for that night until she could find placement for him the next day and said the Administrator told her no Resident #1 was not going back in the facility. She said she told the Administrator she was trying but did not think she would be able to find placement for Resident #1 that day because it was after 5:00 PM and the Administrator told her it was not his problem. She said she was not able to find respite care for the resident at that time. She said she was not comfortable leaving Resident #1 at the facility because he was in his scooter and his battery was going to die but she had been outside the facility with Resident #1 for 2-3 hours and she had to leave. She said she notified the facility that she had to leave, and they told her that it was not their problem he could not stay and by that time night shift was there. She said she left Resident #1 sitting outside under the front cover of the patio with his belongings on the ground at about 7:30pm. She said after she left, she did not get contacted by the facility. She said she found out the next morning that Resident #1 had went to the hospital. She said she was able to find placement the next morning at another facility.</p> <p>During a phone interview on 12/10/2024 at 7:53 PM, LVN F said when she got to the facility at 6:00 pm on 9/12/2024 and she saw Resident #1 in the front of the building calling his family member. She said there were several people with him, but she didn't know who they were. She said she did not see him anymore after that. LVN F said on 9/12/2024 at around 11:00 PM the CNAs took the barrels out to the trash and saw Resident #1 lying on the ground outside at the back of the facility. She said she didn't know if he fell or if he got down on the ground himself. She said Resident #1 was not coherent and was not himself and could not carry on a conversation. She said she did not know if he had taken any medications. She said she did not see any visible injuries, but she could not see in the dark. She said they called 911 for him to be transported to the hospital to be evaluated.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a phone interview on 12/10/2024 at 8:24 PM LVN G said she gets to work at 6pm. She said she saw Resident #1 outside when she got to work on 9/12/2024. She said Resident #1 was outside with a lady but didn't know who she was. She said when she got report and was told Resident #1 had left the building against medical advice and being erratic. She said no one told her he was not allowed to come back in the building. She said she did try to look for Resident #1 by driving around the front and the back of building to see if she could see him. She said she never saw him again that night. She said she didn't know the CNAs had found Resident #1 outside in the back. Said she didn't find that out until days later. She said she had no knowledge of LVN F calling 911 that night.</p> <p>2. Record review of Resident #2's face sheet, dated 12/9/2024, indicated Resident #2 was a [AGE] year old male that admitted to the facility on [DATE] with his most recent admission on 10/01/2024 with diagnoses of fracture of neck, type 2 diabetes mellitus with diabetic polyneuropathy (high blood sugar with nerve damage), and central cord syndrome at unspecified level of cervical spinal cord.</p> <p>Record review of Resident #2's quarterly MDS, dated [DATE], revealed the following:</p> <p>-C0500. BIMS Summary Score= 15 signifying no cognitive impairment.</p> <p>- G0170. A. Roll left and right - The ability to roll from lying on back to left and right side and return to lying on back on the bed. The answer was, Independent.</p> <p>- G0170. B. Sit to lying - The ability to move from sitting on side of bed to lying flat on the bed. The answer was, Independent.</p> <p>- G0170. C. Lying to sitting on side of bed - The ability to move from lying on the back to sitting on the side of the bed and with no back support. The answer was, Independent.</p> <p>- G0170. D. Sit to Stand - The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. The was Independent.</p> <p>- G0170. E. Chair/bed-to-to-chair transfer - The ability to transfer to and from a bed to chair (or wheelchair). The answer was, Independent.</p> <p>- G0170. F. Toilet transfer - The ability to get on and off a toilet or commode. The answer was, Independent.</p> <p>- G0170. FF. Tub/shower transfer - The ability to get in and out of a tub/shower. The answer was, Independent.</p> <p>- Q0400: Discharge Plan A. Is active discharge planning already occurring for the resident to return to the community? The answer for this item was Yes.</p> <p>Record review of Resident #2's care plan dated 11/14/2023 and revised on 11/20/2024 indicated: Resident had an ADL self-care performance deficit and was at risk for not having their needs met in a timely manner with interventions that included: Bed Mobility: independent., Transfers: uses sliding board supervision., Toileting: independent may need assist at times., Ambulation: supervision, Wheelchair: Independent, Dressing: independent, Bathing: independent.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of a document titled, Notice of Discharge of Non-Payment, dated 10/15/2024, revealed Resident #2 was given a 30-day discharge notice on 10/15/2024 with a discharge date of [DATE]. The reasons for discharge were list as: discharge of non-payment . Resident #2 had the right to appeal this action as outlined in DHS' Fair Hearings, Fraud and Civil Rights Handbook by requesting a hearing through the Medicaid eligibility worker at the local DADS office within ten (10) days. The notice was signed by Resident #2 on 10/15/2024.</p> <p>Record review of progress note for Resident #2 dated 11/5/2024 at 11:54 AM written by the Social Worker indicated: the Social Worker met with Resident #2 to discuss discharge plans. The Social Worker discussed the barriers of finding shelter without an income and encouraged Resident #2 to reach out to family and friends for assistance until an income was established. The Social Worker discussed the option of a shelter for discharge. Resident #2 discussed needing a wheelchair prior to discharge. The Social Worker would continue to monitor changes in discharge plans.</p> <p>Record review of progress note for Resident #2 dated 11/14/2024 at 11:50 AM written by LVN D indicated: Resident #2 discharged from the facility on 11/14/2024 at 11:50 AM. A friend assisted in loading Resident #2's belongings and helped with transportation from the facility. Resident #2 was discharged with all medications and instructions.</p> <p>Record review of progress note for Resident #2 dated 11/14/2024 at 12:00 PM written by ADON B indicated: Resident #2 had been discharged home on 11/14/2024. A referral had been made to a durable medical equipment supplier.</p> <p>During an interview on 12/09/2024 at 1:01 PM, ADON A said Resident #2 did not want to discharge from the facility. She said she was not sure where Resident #2 had discharged to, but she thought maybe a homeless shelter. She said the Social Worker had handled Resident #2's discharge.</p> <p>During an interview on 12/09/2024 at 1:15 PM the Social Worker said Resident #2 lost his medical necessity for Medicaid to continue to pay for the resident to be at the facility. She said Resident #2 did not have any income therefore he did not have a way to pay to continue to stay at the facility or to discharge to an assisted living facility. She said she did not know Resident #2 was discharging to a motel until the day Resident #2 discharged . She said discharging to a motel was never a safe discharge. She said the facility was notified from his insurance the day after Resident #2 discharged that Resident #2 met medical necessity for a program called money follows the person. She said to her knowledge Resident #2 did not have an income that he needed to be admitted to an assisted living facility. She said she thought a friend of Resident #2 had picked him up from the facility and drove him to the motel. She said she was not at the facility when Resident #1 had discharged against medical advice from the facility.</p> <p>During an interview on 12/09/2024 at 1:30 PM, MDS E said Resident #2 was denied for medical necessity for Medicaid since August 12, 2024 because he had improved physically. She said Resident #2 was unable to pay or meet medical necessity for Medicaid and needed to discharge from the facility. She said upon discharge she thought he was supposed to be going to stay with his friend. She said the resident was physically able to care for himself and felt like discharging to a motel was a safe discharge.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/10/2024 at 10:14 AM, ADON B said Resident #1 was asked to slow down in his motorized wheelchair on 9/12/2024. She said Resident #1 got irate and started cussing and flying around in his motorized wheelchair at the nurse's station. She said when they told Resident #1 he needed to get in a manual wheelchair he got mad and said he didn't want to be there anymore. She said she told Resident #1 if he was going to leave, she needed him to sign against medical advice paperwork. She said he told her he wasn't signing anything. She said she called the Ombudsman, and the Ombudsman told her that Resident #1 had the right to leave if that was what he wanted. She said she asked Resident #1 to sign the against medical advice paperwork and he still refused to sign the paperwork and was still cussing. She said she let him out the front door and they contacted Hospice RN C at around 4:00 PM. She said Hospice RN C was going to try to find Resident #1 emergency placement. She said when she left a couple hours later Resident #1, and Hospice RN C were outside in front of the facility. She said the Administrator also called hospice and they said Resident #1 was in their care and they were trying to find emergency placement. She said about 11:00pm the nurse at the facility called and told her Resident #1 was sitting outside in his chair. She said the facility nurse called 911 to have him checked out at the hospital. She said Resident #1 was fine, and he was discharged from the hospital. She said while Resident #1 was sitting in front of the hospital in a wheelchair he rolled down the hill and fell out of the chair in the parking lot. She said Resident #1 was then admitted to the hospital after that fall. She said they were never contacted by Hospice RN C for Resident #1 to stay at the facility until placement could be found. She said they did not discharge him onto the street, he was in hospice care outside of the facility. She said at 7:30pm she asked the on-duty nurses to look and see if Resident #1 was still on the property and Resident #1 was not on the property. She Said Resident #2 was supposed to be discharged to assisted living, but he was denied due to not having a payor source. She said Resident #2 had a home to go back to which was living with his cousin, but he didn't want to go back there. She said Resident #2 agreed to go to a motel and Resident #2 and his cousin would figure out living arrangements. She said Resident #2 did not qualify for the money follows the person. She said the day Resident #2 was discharged the cousin picked him up. She said she felt like Resident #2's discharge to a motel was a safe discharge .</p> <p>During an interview on 12/10/2024 at 10:14 AM, the Administrator said Hospice RN C never asked him if Resident #1 could stay at the facility until she could find placement for him. He said when he left the facility on [DATE] Resident #1 and Hospice RN C were in front of the facility and Hospice RN C was on the phone, and he did not speak to her at that time. He said he felt like by Resident #2 discharging to a motel that it was a safe discharge for Resident #2.</p> <p>During an interview on 12/10/2024 at 11:17 AM, the Ombudsman said that she had some concerns with the way the facility had discharged some of the residents. She said she felt like the staff should have tried to reason with Resident #1 after his outburst and allowed him to stay until the Hospice RN C could have found him safe placement. She said she had spoken with the facility Social Worker multiple times regarding Resident #2's discharge. She said Resident #2 had begged the Social Worker and the Administrator to stay at the facility because he had nowhere to go. She said the Social Worker had told her multiple times that Resident #2 could discharge to a homeless shelter and that she had told the Social Worker multiple times that was not a safe discharge. She said she had tried multiple times with the Social Worker to schedule a discharge care plan meeting and it never got scheduled. She said she spoke with the Administrator to try to get a discharge care plan meeting scheduled and then found out that Resident #2 had been discharged .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Willow Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 Whippoorwill Kilgore, TX 75662	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/10/2024 at 10:28 AM, the Social Worker said she had been in constant contact with the Ombudsman. She said Resident #1 had been issued a 30-day discharge notice several times because he had been verbally aggressive in the facility and also had not been paying for his stay. She said he then started paying so the 30-day discharge had been rescinded. She said she contacted hospice for a behavioral hospital referral the day before he discharged, and hospice said no please wait they would do medication changes and they would send out a nurse. She said Resident #1 was known to have behavioral outbursts and was in agreeance to go to the behavioral hospital. She said the next thing she knew he was gone. She said all she could remember was Resident #1 tried to run someone over with his scooter but could not remember anything else specific. She said she was in constant conversation with the Ombudsman about Resident #2's discharge planning. She said without income it was hard to come up with a safe discharge plan. She said she pushed for Resident #2's friends to take him in until he had an income. She said she couldn't send him to the shelter because he would not agree to go. She said the Ombudsman told her it was not a safe discharge for Resident #2 to go to a shelter. She said the Ombudsman did request a discharge care plan meeting, but it never happened. She said she had discussed with Resident #2 what his discharge plans were several times and did think it was necessary to have a discharge care plan meeting.</p> <p>An IJ was identified on 12/10/2024. The IJ template was provided to the facility on [DATE] at 4:28 PM. The facility Administrator, and ADON A, ADON B, RDO, and Regional Nurse Consultant were notified, and a plan of removal was requested.</p> <p>During a phone interview on 12/11/2024 at 2:52 PM LVN H said when she got to work the night of 9/12/2024 Resident #1 was outside with a lady that was on the phone. She said Resident #1 told her that he had been kicked out of the facility. She said at 11:00 pm that night Resident #1 was outside on the ground; there was a wooden ramp and Resident #1 was lying on the ground adjacent to the ramp. She said Resident #1 told her that he was going to lay down on the ramp to sleep. She said the CNAs and LVN F were out there with her. She said the resident was oriented. Said she did not see any injuries, but the resident was diaphoretic (excessive sweating due to an underlying health condition or a medication) and had urinated on himself. She said LVN F took his blood pressure, and it was 240/130 (normal 120/80) which was what prompted the 911 call. She said she was told Resident #1 had left the facility against medical advice and was not allowed back in the facility. She said it was typical behavior for Resident #1 to become verbally aggressive. She said the night before there was an issue about a pain pill, she said he was on scheduled pain medications then medication as needed for breakthrough pain. She said she was told Resident #1 and LVN G began arguing and he threatened to run over the nurse with the scooter.</p> <p>During an interview on 12/11/2024 at 3:25 PM Receptionist J said she worked the evening that Resident #1 discharged from the facility. She said Resident #1 was out back of the facility talking to adult protective services. She said she didn't see Resident #1 when she got back from break about 8:45 PM. She said that Resident #1's behavior in general was aggressive and she witnessed the incident. She said Resident #1 and LVN G were arguing. She said the resident was being discharged due to non-payment, vapes, cigarettes, and wasn't following the rules and telling people that he was going to run them over. She said Resident #1 asked her to let him out the door. She said Resident #1 was going to call someone to pick him up. She said Resident #1 called her back outside for her to get him his phone and chair chargers. She said she stood outside and talked to Resident #1 until hospice got to the facility. She said when she was out back, Resident #1 was out back of the facility, and she gave him a cigarette and lighter about 6:25pm.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Attempted interview on 12/12/2024 at 2:00 PM with the DON. The DON was no available for interview.</p> <p>Attempted interview on 12/12/2024 at 2:05 PM with the Administrator. The Administrator was not available for interview.</p> <p>Record review of facility policy titled Transfer and Discharge (including AMA) dated 10/10/2017 and last reviewed on 9/1/2023 indicated: This facility complies with federal regulations to permit each resident to remain in the facility, and not transfer or dischar [TRUNCATED]</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339</p> <p>Based on observation, interview, and record review the facility failed to ensure the resident environment remains as free of accident hazards as is possible; and Each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 5 (Resident #3) residents reviewed for supervision.</p> <p>The facility failed to respond to door alarm that resulted in Resident #3 elopement on 9/20/2024. Resident #3, who had dementia, left the facility through an alarmed door on 9/20/2024 at 5:05 PM. The resident wandered approximately 200 yards down the road from the facility driveway and was intercepted by Medical Records and returned to the facility.</p> <p>An IJ was identified on 12/11/2024. The IJ template was provided to the facility on [DATE] at 1:55 PM. While the IJ was removed on 12/12/2024, 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 because (e.g.) all staff had not been trained on the facilities missing residents' policy and elopement assessments.</p> <p>This failure could place residents at risk of not being properly supervised resulting in injury or death.</p> <p>Findings included :</p> <p>Record review of Resident #3's facility's electronic face sheet dated 12/11/2024 revealed an [AGE] year-old female admitted to the facility on [DATE] for 3 days respite care with diagnosis of dementia with other behavioral disturbance (problem with thinking and behaviors), senile degeneration of brain (decline in mental abilities), and temporal sclerosis (scarring in the brain).</p> <p>Record review of Resident #3's discharge MDS assessment dated [DATE] revealed a BIMS (brief interview for mental status) score was not obtained. She required supervision or touching assistance with dressing, toilet use and personal hygiene, and required supervision or touching assistance with walking more than 150 feet.</p> <p>Record review of Resident #3's care plan dated 09/20/2024 revealed Resident #3 wandered related to cognitive impairment and was at risk for injury with interventions that included: 1. Attempt to determine any pattern or cause of wandering. 2. Reassure resident when distressed over placement. 3. Redirect is resident enters a restricted area. 4. Notify the immediate supervisor if unable to locate the resident. 5. Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book .</p> <p>Record review of Resident #3's admission elopement risk assessment dated [DATE] at 7:08 PM revealed she was at risk for elopement or unsafe wandering.</p> <p>Record review of hospice admission orders for Resident #3 dated 9/20/2024 indicated: Pt does wander at times.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of nursing progress note for Resident #3 dated 9/20/2024 at 5:46 PM written by LVN O revealed the nurse on 300 hall stated she heard her door alarm go off but saw no one. Room and patient check was done and could not locate Resident #3. A person that worked at the facility called and said on her way home she saw Resident #3 walking toward the school. She called and said she picked the resident up and was bringing her back. Resident #3 was taken to her room and a full body assessment was done with no injuries were noted. The Administrator, ADON B, and DON were notified. Hospice and family were notified. A [NAME] guard was applied to Resident #3.</p> <p>Record review of nursing progress note for Resident #3 dated 9/20/2024 at 8:30 PM written by RN Q indicated a CNA arrived at the facility to sit with Resident #3 to deter wandering behaviors. Resident #3 was in bed sleeping at that time.</p> <p>Record review of nursing progress note for Resident #3 dated 9/20/2024 at 9:00 PM written by LVN Q indicated Resident #3 had 1 to 1 sitter in her room at that time.</p> <p>Record review of nursing progress note Resident #3 dated 9/21/2024 at 2:08 PM written by LVN O indicated Resident #3 attempted to get out of door at the end of the 200 hall and had removed her wander guard. The wander guard was replaced on Resident #3 and LVN O was stationed in the hall to monitor the hall while CNAs could continue to have lunch, make rounds and answer call lights.</p> <p>Record review of nursing progress note for Resident #3 dated 9/21/2024 at 6:19 PM written by LVN O indicated Resident #3 walked up and down the halls several times and was re-directed back to her room. Resident #3 was given a magazine and snacks. Resident #3 walked with her shoes in her hands. She was re-directed for short periods of time.</p> <p>Record review of nursing progress note for Resident #3 dated 9/21/2024 at 7:57 PM written by RN Q indicated the CNA was sitting with Resident #3 in her room while RN Q passed medications. The wander guard was in place.</p> <p>Record review of nursing progress note for Resident #3 dated 9/22/2024 at 1:15 PM written by ADON B indicated Resident #3's family member was at the facility to take her home. Resident #3 was discharged home at that time.</p> <p>During an interview on 12/11/2024 at 10:21 AM Medical Records said she left work about 5:05pm on 9/20/2024. She said she left from the back of the building because her car was parked in the back and there was a driveway behind the facility. She said Resident #3 had just crossed the road behind the facility and was walking towards the school up the road. She said she wasn't for sure if the lady she saw was a resident, so she called another employee at the facility to confirm she was a resident. She said she kept an eye on the lady until she found out if she was a resident at the facility. She said once she confirmed the lady was a resident, she got Resident #3 in her car, and she willingly went back to the facility with her.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation and interviews on 12/11/2024 at 10:45 AM, of the 300-hall door with Medical Records revealed the 300-hall door when pushed opened and alarmed. The exterior gate was unlocked and open. Medical Records and the surveyor walked the path the resident took during elopement. Upon walking around the exterior of the building the exterior gate on both sides of the dining room were unlocked and open. The 500-hall exterior gate was unlocked and open. The 600-hall exterior gate was unlocked and open. The wander guard did not set off the alarm on the 200, 500, 600 halls and did alarm in the dining room after a delay. The alarm on the 300-hall door did alarm with the wander guard (the only hall) but the alarm on the door had a small magnet that slid down the door frame and did not alarm when opened the second time. The Maintenance Director said there was a signal problem with the wander guard as to why the wander guards were not working on all the doors except the 300-hall door.</p> <p>During an interview on 12/11/2024 at 11:00 AM the Maintenance Director said the 300-hall door had a magnet that was attached with double sided tape to the door frame and had slipped down and had to be pushed back up into place for the door alarm to sound when the door opened. He said he would put some new tape on the magnet to hold it in place. He said the magnet would have to be pushed back into place each time the door was opened for the alarm to sound. He said if the magnet was not pushed back into place each time, the door alarm would not sound if the door was opened. He said a resident could get out of the door without the alarm sounding and no one would know. He said there must be a problem with the signal from the wander guards at the doors as to why some of the doors did not alarm when the wander guard was close to the doors. He said after the elopement he checked all doors, and all doors were functioning properly.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/11/2024 at 11:32 AM LVN O said she was not notified that she would be getting an admission on 9/20/2024. She said Resident #3 admitted at a little after 8:00 am on 9/20/2024. She said the Administrator brought Resident #3 and showed her the room and then left and did not give her any paperwork or admission orders for Resident #3. She said she called the DON and asked for admission orders and paperwork. She said the DON told her the Administrator had the orders and must have locked them up in his office, so she had to wait till hospice came about 3:00 pm before receiving admission orders and paperwork. LVN O said she was at the end of the 200 hall doing blood sugar checks and could not hear the alarm going off. She said LVN P asked her if she was missing a resident around 5:00 PM. She said she never heard an alarm going off. She said once she got back to the nurse's station, she heard the alarm going off on the 300 hall. She said they started doing a head count. LVN O said she drove around the building and then went down the main road. She said she made it back to the facility and by that time Medical Records had picked Resident #3 up by the school and brought her back to the facility. She said she notified the Administrator and the DON of the elopement. She said once Resident #3 was back at the facility she did an assessment and then Resident #3 ate dinner and went to bed. She said the next day Resident #3 took the wander guard off and was walking down the hallway. LVN O said she got a table and chair and sat in the hall by her room for the rest of the day and did not have any further incidents. LVN O said she got a call from the DON and told her not to come in the next day on Sunday 9/22/2024 that she was suspended pending investigation of the elopement. She said ADON B then called and told her all was clear and go ahead and come back to work on Wednesday 9/25/2024. LVN O said then she received another call from the DON and told her to go the Administrator's office and don't clock in on Wednesday. She said on Wednesday the Administrator and DON told her the CEO told them to terminate her due to the elopement. LVN O said prior to the elopement she had no paperwork that said Resident #3 was an elopement risk. LVN O said after she received the hospice orders on the back sheet of the hospice paperwork it said Resident #3 wandered. She said hospice told her Resident #3 wandered around the house but never made an attempt to get out of the house. LVN O said Resident #3 was outside of the facility for maybe 10-15 minutes. She said typically when a resident admitted the nurse did an elopement assessment upon admission.</p> <p>An IJ was identified on 12/11/2024. The facility Administrator, and ADON A, ADON B, RDO, and Regional Nurse Consultant were notified, and a plan of removal was requested.</p> <p>Attempted interview on 12/12/2024 at 2:00 PM with the DON. The DON was no available for interview.</p> <p>Attempted interview on 12/12/2024 at 2:05 PM with the Administrator. The Administrator was not available for interview.</p> <p>Record review of the facility's Missing Residents policy dated 10/24/2022 revealed This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. 4: monitoring and managing residents at risk for elopement or unsafe wandering: A- residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team.</p> <p>The facility's plan of removal was accepted on 12/12/2024 at 1:37 p.m. and included:</p> <p>4. Immediate Action Taken</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>G. Resident #3 is no longer in the facility as of September 23, 2024.</p> <p>H. On 12/11/2024 The Maintenance Director/Designee completed environmental assessments to include checks on all doors.</p> <p>I. On 12/11/2024 The ADON and/or designee completed elopement assessments on all facility residents with no changes noted.</p> <p>J. On 12/11/2024 The ADON and/or designee completed in-service education with facility direct care nursing staff on the missing resident policy which ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents. The facility RNC completed in-service education with the facility Admin and ADONs. Facility direct care nursing staff were trained prior to their next shift. The Missing Resident Policy Inservice Education included Residents will be assessed within 4 hours for risk of elopement and unsafe wandering upon admission, quarterly, and as needed throughout their stay at the facility.</p> <p>K. On 12/11/2024 The ADON and/or designee completed a Missing Resident Drill with facility direct care staff to ensure staff know the proper procedure for locating missing residents to include when a staff member hears the alarm sound they will initiate the code silver alert to notify all other staff members of the missing resident. Facility direct care staff completed a missing resident drill prior to their next shift.</p> <p>This was completed on 12/11/2024 by 10:00 pm.</p> <p>L. On 12/12/24 The facility RNC completed in-service education with the facility Administrator regarding do not take a resident to their room without notifying the admitting nurse and providing the admission paperwork to them.</p> <p>5. Identification of Residents Affected or Likely to be Affected:</p> <p>C. No other residents identified , on 12/11/24 the facility ADON and/or Designee completed elopement assessments on all facility residents with no new changes noted. This will be completed on 12/11/24 by 10:00 pm.</p> <p>3.Actions to Prevent Occurrence/Recurrence:</p> <p>D. As of 12/11/2024, any staff member hired for direct nursing staff the following will be completed during orientation by the facility DON and/or designee:</p> <p>In-service education with facility direct care nursing staff on the missing resident policy which ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents.</p> <p>The DON and/or designee will complete a Missing Resident Drill with facility direct care staff during orientation to ensure staff know the proper procedure for locating missing residents to include when a staff member hears the alarm sound they will initiate the code silver alert to notify all other staff members of the missing resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>E. The ADON/Designee will conduct weekly random missing resident drills two (2) times a week for six (6) weeks to ensure facility staff know the proper procedure for locating missing residents to include when a staff member hears the alarm sound they will initiate the code silver alert to notify all other staff members of the missing resident.</p> <p>F. Results of weekly observations will be reviewed in the morning meeting by the Administrator or designee.</p> <p>On 12/11/2024 the facility's Administrator notified the Medical Director to conduct an AdHOC QAPI meeting regarding the Immediate Jeopardy the facility received related to Free of Accidents/ Hazards/ Supervision and reviewed plan to sustain compliance</p> <p>On 12/12/2024 the Surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by:</p> <p>Record review of the electronic medical record indicated Resident #3 discharged from the facility on 9/22/2024.</p> <p>Record review of completed environmental assessments dated 12/11/2024 to include checks on all doors.</p> <p>Observation on 12/12/2024 at 3:00 PM of all facility doors will all door alarms currently working.</p> <p>Record review of elopement assessments dated 12/12/2024 on all 9 residents identified as elopement risks.</p> <p>Record review of an in-service dated 12/11/24 at 2:30pm titled Missing Person Policy revealed it was signed by the Administrator, ADON A, and ADON B.</p> <p>Record review of an in-service titled Elopement/Missing Person Drill dated 12/11/24 revealed it was signed by 52 employees of various disciplines and shifts.</p> <p>Record review of an in-service titled Do not take a resident to their room without notifying the admitting nurse . dated 12/12/24 revealed it was signed by the Administrator.</p> <p>Record review of an off cycle AdHoc QAPI meeting held on 12/11/24 at 3:35pm to discuss accidents, Hazards and Supervision.</p> <p>The following interviews were conducted to ensure staff understood education received:</p> <p>During an interview on 12/12/2024 at 3:40 PM ADON A said the following were steps in searching for a missing resident: page a silver alert, print the census and check for missing residents, perform a head count. She said she would start searching the facility grounds for the missing resident. She said she would notify the physician, family, DON, Administrator, and police. Once the resident was found a complete head to toe assessment should be done. She said the elopement assessment should be completed within four hours of admission.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Willow Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 Whippoorwill Kilgore, TX 75662	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/12/2024 at 3:44 PM LVN K said the following were steps in searching for a missing resident: Page code silver, head count, search, notify the MD, family and police. She said the elopement assessment was to be completed within 4 hours of admission.</p> <p>During an interview on 12/12/2024 at 3:48 PM LVN L said the following were steps in searching for a missing resident: Call silver alert, start a head count, search, notify the Administrator, DON, family and police. She said the elopement assessment was to be completed within 4 hours of admission.</p> <p>During an interview on 12/12/2024 at 3:50 PM LVN D said the following were steps in searching for a missing resident: Call silver alert, start head count, searching, notify physician, family and Police. He said the elopement assessment is to be completed within 4 hours of admission.</p> <p>During an interview on 12/12/2024 at 3:52 PM RN M said the following were steps in searching for a missing resident: Call silver alert, start head count, identification, search, notify the physician, family, and police. He said the elopement assessment was to be completed within 4 hours of admission.</p> <p>During an interview on 12/12/2024 at 3:54 PM ADON B said the following were steps in searching for a missing resident: Call code silver, start a head count, identification, search, notify the physician, Administrator, police, and family. She said the elopement assessment was to be completed within 4 hours of admission.</p> <p>During an interview on 12/12/2024 at 3:59 PM MDS N said the following were steps in searching for a missing resident: Call silver alert, start a head count, search, notify the Administrator, DON, family and police. She said the elopement assessment was to be completed within 4 hours of admission.</p> <p>During an interview on 12/12/2024 at 4:01 PM MDS E said the following were steps in searching for a missing resident: Call code silver, start a head count, identification, search, notify the physician, Administrator, police, and family. She said the elopement assessment was to be completed within 4 hours of admission.</p> <p>During an interview on 12/12/2024 at 4:03 PM CNA R said the following were steps in searching for a missing resident: Call code silver, search, head count, call 911.</p> <p>During an interview on 12/12/2024 at 4:04 PM CNA S said the following were steps in searching for a missing resident: Call silver alert, head count, search, and call 911.</p> <p>During an interview on 12/12/2024 at 4:06 PM MA U said the following were steps in searching for a missing resident: Call code silver, search, head count, and call 911.</p> <p>During an interview on 12/12/2024 at 4:08 PM CNA T said the following were steps in searching for a missing resident: Call code silver, head count, search, and call 911.</p> <p>On 12/12/2024 at 4:15 p.m., ADON A, ADON B, and Regional Nurse Consultant were notified the IJ was removed. However, the facility remained out of compliance at a level of no actual harm with the potential for more than minimal harm with a scope identified as isolated due to the facility's need to monitor the implementation and effectiveness of its POR.</p>		