

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 01/30/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 6 (Resident #72) residents reviewed for call lights.</p> <p>The facility failed to ensure Resident #72's call button was within reach while Resident #72 was in her bed.</p> <p>This failure could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity.</p> <p>Findings included:</p> <p>Record review of Resident #72's face sheet, dated 01/25/24 indicated Resident #72 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Dementia (memory loss), high blood pressure, and Gastroesophageal Reflux Disease also known as GERD (is a chronic digestive condition where stomach contents flow back up into the esophagus, causing irritation and various symptoms).</p> <p>Record review of Resident #72's annual MDS assessment, dated 01/10/25, indicated that she understood and was understood by others. Resident #72 had a BIMs score of 03 which indicated she was cognitively impaired. Resident #72 required assistance with bathing. The MDS indicated she was occasionally incontinent of bowel and bladder.</p> <p>Record review of Resident #72's Comprehensive Care Plan dated 02/20/24 reflected Resident #72 had the potential for falls related to unsteady gait at times. The intervention was for staff to place the resident's call light within reach and encourage the resident to use it for assistance as needed.</p> <p>During an observation and interview on 01/27/25 at 9:09 a.m., revealed Resident #72 was sitting on the side of her bed. No call light was noted within reach. A call light was hanging on the wall behind the room divider curtain. Resident #72 said she did not know where her call light was. SHe, she said if she needed anything she would walk to the door to alert staff.</p> <p>During an observation on 01/27/25 at 2:38 p.m., revealed Resident #72 was walking back from the bathroom with her walker and sat on the side of her bed. The call light was hanging on the wall behind the room divider curtain.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 01/27/25 at 2:44 p.m., revealed the Treatment Nurse entered Resident #72's room and said she did not see her call light. She then looked behind the curtain and saw the call light hanging against the wall. She said the call light should be within Resident #72's reach in case she needed it. She said all staff was responsible for ensuring the call light was within reach. She said the risk could be the resident would not get help if needed.</p> <p>During an interview on 01/29/25 at 03:50 p.m., ADON #2 said all residents should have a call light and should always be within reach. She said if a resident did not have their call light it could lead to falls or the resident not getting the help they need.</p> <p>During an interview on 01/29/25 at 03:50 p.m., the DON said she expected call lights to be accessible to the residents. She said all staff should check on the residents and ensure they have a call light and that the call light was within reach. The DON said failure to have or keep the call lights within reach could cause a resident to fall.</p> <p>During an interview on 01/29/25 at 04:21 p.m., the Administrator said she expected all call lights to be working and within reach of each resident. She said all staff should ensure the call lights were within reach. She said call lights were a way for the residents to communicate if they needed anything.</p> <p>Record review of the facility policy title, Call Light Response, dated 02/10/21 indicated, The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or a centralized location to ensure appropriate response. #5 With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of the resident and secure as needed.</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879</p> <p>Based on interviews, and record review, the facility failed to ensure the right to be free from misappropriation of resident property for 1 of 6 residents reviewed for misappropriation of resident property. (Resident # 85)</p> <p>CNA T used Resident #85's debit/credit card for her personal use on various dates.</p> <p>This failure could place residents at risk for decreased quality of life, misappropriation of property, and dignity.</p> <p>Findings included:</p> <p>Record review of Resident #85's face sheet, dated 01/29/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included Dystonia (a neurological movement disorder characterized by involuntary, sustained, or repetitive muscle contractions that cause abnormal postures or movements), anxiety disorder (feelings of nervousness, panic, or fear), diabetes and high blood pressure.</p> <p>Record review of Resident #85's admission MDS assessment, dated 12/09/24, indicated Resident #85 understood and was understood by others. Her BIMs score was 12, which indicated she was moderately cognitively impaired.</p> <p>Record review of the care plan dated 12/26/24 indicated Resident #85 had impaired cognition and was at risk for a further decline in cognitive and functional abilities related to the diagnosis of mild cognitive impairment. The intervention was for staff to engage in simple, structured activities that avoid overly demanding tasks and provide instructions to the resident using clear voice and simple sentences. Repeat as needed and allow resident time to respond.</p> <p>Record review of the Provider Investigation Report dated 01/08/25 indicated Resident #85 was asked on 01/08/25 if she knew why money was being transferred to CNA T's Cash App (a digital wallet application that allows users to send, receive, and save money) account. Resident #85 said she was not aware of any money being transferred to CNA T or ever using Cash App for any activity in the past or currently. Resident #85 showed the previous Administrator, and the Business Office Manager her phone and permitted them to review her phone for a Cash App. Neither the previous interim Administrator nor the Business Office Manager could find any evidence of the Cash App being on Resident #85's phone. Bank statements were received from Resident #85's account. The bank statements indicated money was being transferred via Cash App from the account of Resident #85 to CNA T on multiple dates and times. Resident #85 denied having authorized any ATM withdrawals or Cash App money transfers for CNA T.</p> <p>(continued on next page)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the Provider Investigation Report dated 01/08/25 further indicated CNA T said Resident #85 had asked her a couple of times around Christmas 2024 to go shopping at Walmart and the dollar store. CNA T said she bought Resident #85 some outfits, snacks, a refrigerator, and some cash back. CNA T said Resident #85 gave her the PIN to her card so that she could bring some cash back; around \$300 to 400 dollars. CNA T said she asked Resident #85 if she was supposed to have that much money and Resident #85 said they could not tell her how to spend her money. CNA T said she gave the cash and the items to Resident #85 but did not keep any receipts. She said that occurred around Christmas time and then again, a couple of weeks ago when she used the ATM at Walmart. CNA T said Resident #85 kept telling her she had to pay a \$100 copay at the doctor's office and other stuff. CNA T said no other resident had asked her to go shopping for them. CNA T said Resident #85 gave her the PIN to her card and permission to use her card. She said she would not have had her card or PIN without her consent.</p> <p>Record review of the Provider Investigation Report further indicated on the bank statements, dated 01/09/25, the following transactions were:</p> <p>12/24/24? ?\$2.00----fee for checking the account</p> <p>12/24/24? ?\$3.00----fee for withdrawal</p> <p>12/24/24? ?\$3.00----fee for withdrawal</p> <p>12/24/24? ?\$30.00--- NSF (non-sufficient funds (NSF) fee is a charge a bank imposes when a transaction is declined due to insufficient funds in an account)</p> <p>12/24/24? ?\$30.00---NSF</p> <p>12/24/24? ?\$400.00----withdrawal</p> <p>12/24/24? ?\$100.00----withdrawal</p> <p>12/30/24? ?\$10.00----Cash App</p> <p>12/30/24? ?\$10.00----Cash App</p> <p>12/30/24? ?\$25.00---withdrawal in [city name]</p> <p>12/30/24? ?\$30.00---NSF</p> <p>12/30/24? ?\$30.00----NSF</p> <p>12/30/24? ?\$30.00----NSF</p> <p>12/30/24? ?\$30.00----NSF</p> <p>12/30/24? ?\$200.00----Cash App</p> <p>01/06/25? ?\$10.00----Cash App</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>01/06/25? ?\$10.00----Cash App</p> <p>01/06/25? ?\$3.00---service card</p> <p>01/06/25? ?\$10.00----Cash App</p> <p>01/06/25? ?\$10.00----Cash App</p> <p>01/06/25? ?\$10.00----Cash App</p> <p>01/06/25? ?\$200.00----Cash App</p> <p>Total amount withdrawn was: \$1,186.00</p> <p>During an interview on 01/27/25 at 3:14 p.m., the Business Officer Manager said she, the interim Administrator, the DON, the Social Worker, and the Ombudsman met with Resident #85 on 01/08/25 to discuss applied income and payment due to the facility. She said during the conversation Resident #85 said she did not have any money because she had given a staff member her credit card to go shopping for herself and her family member, who was also a resident in the facility, and all their money was gone. The Business Officer Manager asked Resident #85 if she could have permission to call the bank and receive her statements. Resident #85 gave her permission and was also present when she called the bank. After receiving the bank statements, the facility saw the transactions where CNA T was sending money via Cash App to herself from Resident #85's account. The Administrator then did a self-report to the state agency. She said she recalled the bank and set up a trust fund for Resident #85 to prevent further exploitation. She said Resident #85 admitted to giving CNA T her PIN and credit card. She said she totaled the amount stolen from resident #85's account to be \$455.00. The Business Officer Manager said as of today (01/27/25) she had not been told to replace Resident #85's money.</p> <p>During a phone interview on 01/27/25 at 3:52 p.m., the assigned Detective said he went to the facility and spoke with the staff and Resident #85. He said they had to get a subpoena for the Cash App record, and it would take a few weeks. He said once they received the records and could prove CNA T had sent the money to her personal account she would be charged with financial abuse of an elderly. He said he had tried to contact CNA T but she did not answer.</p> <p>During an interview on 01/28/25 at 3:01 p.m., Resident #85 said when she and her family member (who was also a resident) arrived at the facility they were homeless because they were kicked out of their house by the landlord. She said CNA T was a staff member who was helping them go get some things they needed but it turned out she took from Resident #85 and she was unsure of how much the aide took. Resident #85 said the Business Officer Manager knew how much money was stolen from her. She said CNA T stole her information and put it on her cash app. Resident #85 said the police were also aware of what CNA T had done and the amount of money she had stolen from her. She said she was upset about the whole situation. Resident #85 admitted she gave CNA T her PIN and credit card to buy things for her such as Dr Pepper, clothes, and a refrigerator and she said CNA T did buy what she had asked for. She said that unknown to her CNA T took out some more money without her consent and sent it to her own Cash App. She said she was going to file charges against CNA T because what she did was wrong. She said she was not sure if the facility was going to return her money but knew they were working on getting everything straight.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an attempted phone interview on 01/28/25 at 3:51 p.m., CNA T did not answer, and a message was left.</p> <p>During an interview on 01/29/25 at 3:20 p.m., ADON F said she expected staff to notify the activity director if any resident wanted something. She said she was aware that Resident #85's credit card had been used by CNA T but was unaware of the whole process because the Administrator and the DON handled it. She said she knew they did an in-service on exploitation with the staff.</p> <p>During an interview on 01/29/25 at 3:50 p.m., the DON said they were having a meeting with Resident #85 and her family member who was also a resident, along with the Business Office Manager, the Ombudsman, the interim Administrator, and herself. She said during the meeting Resident #85 said she did not have any money, and when questioned further she said she had given her credit card to CNA T. Resident #85 did admit she gave CNA T her credit card and PIN. She said the Business Office manager got the bank statements, reviewed them, and saw some cash app activity in CNA T's name. They then called the police and reported this incident to the state agency. She said she did go to Resident #85's room and saw they had some new clothes and bedding. She said they called CNA T who admitted she had gone shopping for Resident #85. She said they immediately suspended CNA T pending investigation. She said after reviewing the bank statements and CNA T admitted she had used the credit card the investigation was completed and Resident #85's misappropriation allegation was substantiated because it did happen. She said they terminated CNA T. She said CNA T should not have taken any resident's credit card. She said the staff were not allowed to take money, credit cards, or anything else from the resident. She said they did an in-service on abuse, neglect, and exploitation.</p> <p>During an interview on 01/29/25 at 421 p.m., the Administrator said she was not employed at the facility when Resident #85's credit card was used. She said they should have been educated on exploitation. She said she did not expect staff to take money or credit cards from any residents. She said they had a process in place for the activity director to shop for all residents.</p> <p>During a phone interview on 01/30/25 at 02:30 p.m., the previous Administrator said they went to have a meeting with Resident #85 and her family member who was a resident about paying their bill to the facility. He said the Ombudsman, the Business Office Manager, and the DON were present during the meeting. He said while talking to Resident #85 she said the CNA kept taking her money, so he started asking when that happened. Resident #85 said it occurred around Christmas 2024. Resident #85 said they needed a few things, so she gave CNA T her credit card and PIN. Resident #85 said CNA T did get the things they needed and returned her credit card. Resident #85 said she noticed money was missing from her bank account but did not tell anyone. Resident #85 said she was paid last week (unknown date) but yet she had no money. The Administrator said he and the Business Office Manager asked if they could get her bank statements and she agreed. We reviewed the bank statements and saw where CNA T was receiving money on her cash app from Resident #85's account. He said he asked Resident #85 again if she approved the transactions done by CNA T and she said, No. He said they asked if they could look at Resident #85's phone and she agreed, and they did not see an application for Cash App on her phone. He said he then collected all the information and sent it to his cooperate office to report it to the Health and Human Services and called the police. The previous Administrator said they did an off-cycle Quality Assurance (QA) and Performance Improvement (PI) meeting where they discussed the credit card issues and came up with a plan for the activity director to only get money for the resident. He said that the resident must be present, tell both the Business Office Manager and the Activity Director what they need, and sign out for the money. He said an in-service was done on abuse, neglect, and exploitation. He said no staff should take money or credit cards from a resident.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the in-service done on 01/08/25 about abuse, exploitation, misappropriation, and taking money and/or credit cards from residents.</p> <p>Record review of the Abuse Neglect and Exploitation, dated 10/24/22, indicated, Policy statement: it is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Definition of exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. Misappropriation of Resident Property: means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, threats, or coercion. III. Prevention of Abuse, Neglect, and Exploitation: The facility will make every effort to prevent and prohibit all types of abuse, neglect, misappropriation of residents' property, and exploitation that achieves: B. Identifying, correcting, and intervention is in situations in which abuse, neglect, exploitation, and/or misappropriation of residents property is suspected or identified by: taking immediate action to correct any issues that can reduce the risk of further harm continuing or occurring to residents or other residents'. A. The facility assists staff in understanding the different types of abuse: mental, verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff-to-resident abuse and certain residents-to-resident altercations. VI. Protection of Resident: the facility makes efforts to ensure all residents are protected from psychosocial harm as well as additional abuse during and after the investigation. A. Respond immediately to protect the alleged victim and the integrity of the investigation.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929</p> <p>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 #32) reviewed for PASRR Level I screenings.</p> <p>The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #32. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnoses (major depressive disorder and post-traumatic stress disorder) were present upon Resident #32's admitted on 04/21/22.</p> <p>This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs.</p> <p>Findings included:</p> <p>Record review of Resident #32's face sheet, dated 01/27/25, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included major depressive disorder (a mental illness that causes a persistent low mood and loss of interest in activities) with an onset date of 04/25/19, and post-traumatic stress disorder (a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events or set of circumstances) with an onset date of 02/23/21.</p> <p>Record review of Resident #32's annual MDS assessment, dated 12/27/24, indicated she had a BIMS score of 15, which indicated intact cognition. The assessment further indicated she received an antianxiety and antidepressant medication during the assessment window.</p> <p>Record review of Resident #32's PASRR Level 1 Screening, dated 12/18/24, indicated that in Section C, Mental Illness was marked as no, which indicated Resident #32 did not have a mental illness.</p> <p>During an interview on 01/29/25 at 09:40 AM, MDS coordinator D said she did not think Resident #32 would be PASRR positive if a PL1 was submitted with mental illness marked yes. She said Resident #32 did not have a recent hospitalization related to her mental illness so she would likely not qualify for PASRR services.</p> <p>During an interview on 01/29/25 at 10:09 AM, MDS coordinator D said she did not think the PL1 form dated 12/18/24 should have been marked yes for mental illness because the form was completed due to a change of ownership. She said since she thought that Resident #32 was unlikely to become PASRR positive she did not think the form needed to be fixed and resubmitted. She said if the local authority had come out to the facility, she did not think Resident #32 would have been deemed PASRR positive for mental illness.</p> <p>During an interview on 01/29/25 at 01:48 PM, the Administrator said she had worked at the facility for 3 days. She said she was not clinical and was not sure how to answer this surveyor's questions related to PASRR.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy, Preadmission and Screening Resident Review (PASRR) Rules, last revised July 2023, stated:</p> <p>.It is the intent of [corporate name] to meet and abide by all state and federal regulations that pertain to resident preadmission and screening resident review (PASRR) rules .</p> <p>.Referring Entity completes a PL1 .</p> <p>.if negative:</p> <p>.If the resident has a qualifying MI (mental illness) diagnosis and the NF feels the resident should be positive they should talk to the referring entity and ask them to correct the PL1 .</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879</p> <p>Based on interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene were provided for 1 of 6 residents (Residents #74) reviewed for ADL care.</p> <p>The facility failed to ensure Resident #74 was showered on 01/01/25, 01/06/25, 01/13/25, 01/15/25 and 01/20/25.</p> <p>This failure could place residents at risk of not receiving care/services, decreased quality of life, and loss of dignity.</p> <p>Findings included:</p> <p>Record review of Resident #74's face sheet, dated 01/29/25, indicated a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included stroke, depression (sadness), diabetes, and high blood pressure.</p> <p>Record review of Resident #74's quarterly MDS assessment, dated 11/06/24, indicated Resident #74 understood and was understood by others. His BIMs score was a 14, which indicated he was cognitively intact. The MDS indicated he required touch assistance for showering, limited assistance for dressing, and maximum assistance for transferring.</p> <p>Record review of the care plan dated 08/12/24 indicated Resident #74 had an ADL self-care performance deficit and was at risk for not having his needs met in a timely manner related to Hemiplegia (a medical condition characterized by paralysis or weakness on one side of the body) affecting the right dominant side and weakness. The interventions were for staff to assist with bathing.</p> <p>During an interview on 01/28/25 at 12:17 p.m., Resident #74 said he was not getting his showers 3 times a week. He said he was lucky to get a shower 1 time a week. He said he had told the Administrator about missing his showers. He said staff would start giving him showers 3 times a week for a while and then would slack off again. He said he would like to get his showers 3 times a week.</p> <p>Record review of Resident #74's point of care history dated 01/01/25-01/31/25, did not indicate Resident #74 was bathed on the following dates: 01/01/25, 01/06/25, 01/13/25, 01/15/25 and 01/20/25.</p> <p>During an interview on 01/29/25 at 11:08 a.m., CNA O said she had given Resident #74 a shower on her day shifts several times. She said he was a Monday, Wednesday, and Friday night shift shower. She said he would ask her to shower him because he had not received his shower on the night shift.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Willow Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 Whippoorwill Kilgore, TX 75662	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and record review on 01/29/25 at 10:36 a.m., LVN P said showers should be given according to the shower schedule. LVN P said A beds (beds closer to the door) were day shift showers and B beds (closest to the window) were night shift showers. He said periodically they would have residents who would say they did not receive their baths, but staff would make sure they got them. LVN P said the nurses were responsible for ensuring the baths were provided. He said when the aides gave a shower, they would bring the shower sheets so that the nurses could sign the shower sheets indicating the shower had been given and place the signed sheet in the shower book. LVN P and the state surveyor looked through the shower book and could not locate any shower sheets for Resident #74 for January 2025. He said he was not aware Resident #74 was not receiving his showers.</p> <p>During an interview on 01/29/25 at 3:20 p.m., ADON F said Resident #74 should be getting his showers 3 times a week. She said she was not aware of Resident #74 refusing his showers. She said if he did refuse his showers then the charge nurse should document the refusal in his chart. She said failure to receive a shower, or a missed shower could lead to skin issues.</p> <p>During an interview on 01/29/25 at 3:50 p.m., the DON said she expected showers to be given according to the shower schedule. She said the staff was aware of the shower days because it was on point of care and the task assignment. She said she was unaware of Resident #74 missed showers. She said if a resident refused his/her shower(s) then the charge nurse was supposed to document it in his/her chart and depending on how many refusals notify the responsible party. She said showers should be given for cleanliness and prevention of skin breakdown.</p> <p>During an interview on .01/29/25 at 4:21 p.m., the Administrator said she started at the facility 01/27/25. She said she expected the residents to receive their baths and expected the staff to document if they did not receive them. The Administrator said the charge nurse was responsible for ensuring the showers were completed. She said showers were given for sanitary and infection reasons.</p> <p>Record review of the facility policy titled, Resident Showers, dated 02/11/22 indicated, It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues as per current standards of practice.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 45643</p> <p>Based on observation, interview, and record review the facility failed to ensure the resident environment remained as free of accident hazards as is possible for 3 of 5 residents (Resident #20, Resident #76, Resident #5) reviewed for quality of care.</p> <p>The facility failed to prevent Resident #20 from having rubbing alcohol in his room.</p> <p>The facility failed to ensure Resident #76 did not have 5 razors in his room.</p> <p>The facility failed to ensure Resident #5's fall mat was beside his bed on 01/28/25 and 01/29/25.</p> <p>This failure could place residents at risk for injury, harm, and impairment.</p> <p>Findings included:</p> <p>1. Record review of Resident #20's Admission Record indicated he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Hypothyroidism (A condition in which the thyroid gland doesn't produce enough thyroid hormone), Insomnia (a sleep disorder that makes it difficult to fall asleep, stay asleep, or get quality sleep), and Mild Cognitive Impairment (a condition where a person has more memory or thinking difficulties than others their age).</p> <p>Record review of Resident #20's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 07 which indicated severe cognitive impairment. The MDS also revealed Resident #20 was understood and understood others. The MDS reflected Resident #20 required assistance with activities of daily living.</p> <p>Record review of Resident #20's Care Plan , revealed a problem initiation on 9/18/2021 reflected Resident #20 had impaired cognition and was at risk for a further decline in cognitive and functional abilities related to age process.</p> <p>During an interview and observation on 1/27/25 at 10:55 a.m. revealed Resident #20 had a bottle of 91% Isopropyl Alcohol on his bedside dresser. He said he used it to clean between his toes. He said he had it for months.</p> <p>During an interview and observation on 1/27/25 at 3:30 p.m., LVN C said that residents were not allowed to have rubbing alcohol on their room. She said that there was a risk that a resident could get ahold of the alcohol and drink it. She said that residents could be placed at risk of poisoning if they drank rubbing alcohol. LVN C was observed removing the rubbing alcohol from the Resident #20's room.</p> <p>During an interview on 1/29/25 at 1:29 p.m., CNA A said that if she found a bottle of rubbing alcohol in a resident's room it should go to the nurse's station as those types of items were not allowed in a resident's room unsupervised. She said there was a risk of poisoning if a resident drank rubbing alcohol.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/29/25 at 2:09 p.m., the Director of Nurses said residents were not allowed to keep rubbing alcohol in their rooms. She said that all staff were responsible to ensure that those types of items were not in the resident's rooms. She said residents could be placed at risk of ingesting the alcohol and subsequent poisoning could occur.</p> <p>During an interview on 1/29/25 at 2:12 p.m., the Administrator said residents were not allowed to keep rubbing alcohol in their rooms. She said that all staff that entered a resident's room and saw an item they were not allowed to have should confiscate that item. She said that residents could be placed at risk of swallowing the alcohol.</p> <p>45810</p> <p>2. Record review of Resident #76's face sheet dated 01/29/25 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses of mild cognitive impairment, high blood pressure, heart disease, and generalized muscle weakness.</p> <p>Record review of Resident #76's quarterly MDS dated [DATE] indicated he was understood and could understand others. The MDS also indicated he had a BIMS score of 14 which meant he was cognitively intact. The MDS also indicated Resident #76 required supervision assistance with personal hygiene.</p> <p>Record review of Resident #76's care plan dated 06/27/24 indicated he had impaired visual function with interventions for staff to anticipate his needs and keep the call light in reach when in room or in the bathroom. The care plan dated revised on 06/27/24 indicated he had ADL self-care deficit and required limited assistance with personal hygiene.</p> <p>During an observation and interview on 01/27/25 at 09:36 AM revealed Resident #76 was in his room sitting in his wheelchair looking at his phone. He had 5 blue razors on the back of his bathroom sink. Resident #76 said he completed his shaving when he needed to, and the staff would normally give him the razors and he kept them in his bathroom.</p> <p>During an observation on 01/28/25 at 09:07 AM revealed Resident #76 continued to have 5 blue razors on the back of his bathroom sink.</p> <p>During an interview on 01/29/25 at 3:24 PM CNA H said she was unsure why Resident #76 had the 5 blue razors in his bathroom. She said she had just returned to work on 01/29/25 from her off days. CNA H said that if she had given Resident #76 the razors to shave, she would have removed the razors when he was finished with the shave. CNA H said the failure placed a risk for other residents that wander to get the razors and possibly cut themselves.</p> <p>During an interview on 01/29/25 at 03:44 PM ADON F said her expectation was for the razors to be given to the resident when they were needed and when Resident #76 completed the shave the CNAs should have gotten them back from him and placed the razors in the sharp's container. ADON F said all staff were responsible for ensuring no residents had razors or hazardous items a left in the rooms or bathrooms. ADON F said the failure placed all residents at risk for cuts or injury.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/29/25 at 04:23 PM the DON said her expectation was for the CNAs to follow the care plan and tasks needed for Resident #76 and for the CNA to follow up with independent residents and discard the razors in the sharps container as they were supposed to be discarded. The DON said every staff was responsible for ensuring things like razors were not left out in the resident's room. The DON said the failure placed risk for injury for Resident #76 and other residents who wander may get the razors.</p> <p>During an interview on 01/29/25 at 04:47 PM The Administrator said her expectation was for the staff to monitor the razors when the residents had them and when the residents were finished using the razors they should have been removed and placed them the sharps container. The Administrator said the failure of leaving the razors out in Resident #76's bathroom placed a risk is for resident cuts or injuries. She said the facility had residents who may have wandered in #76's room and may not have known how to use the razors that were left out. She said she expected the staff who gave residents the showers and shaves were responsible for ensuring the razors were not left in the residents' rooms.</p> <p>45879</p> <p>3. Record review of Resident #5's face sheet, dated 01/29/25 indicated she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia (loss of memory), stroke, anxiety (feelings of worry, fear, unease, and apprehension), and diabetes (when your blood sugar is too high).</p> <p>Record review of Resident 5's annual MDS assessment, dated 11/04/24, indicated Resident #5 sometimes understood and was sometimes understood by others. Resident #5's BIMS score was 00 indicating her cognition was severely impaired. The MDS indicated Resident #5 required extensive assistance with her ADL's including transfers and bed mobility. The MDS indicated she had a fall in the prior assessment.</p> <p>Record review of Resident #5's comprehensive care plan dated 11/17/23 indicated, Resident #5 had the potential for falls related to Hemiplegia/Hemiparesis (a medical condition characterized by paralysis or weakness on one side of the body) affecting the left non-dominant side. The intervention was for staff to apply a fall mat at the bedside.</p> <p>Record review of Resident 5's incident report revealed she had a fall from her bed on 09/11/24 and 09/21/24.</p> <p>During an observation and interview on 01/28/25 at 9:11 a.m., revealed Resident #5 was in her bed with the fall mat beside the wall. No fall mat was noted beside her bed. CNA Q verified the fall mat was not beside Resident #5's bed and said the fall mat should be down because she was at risk of falling. She said she was her aide for the day but did not realize the fall mat was not down.</p> <p>During an observation and interview on 01/29/25 at 10:14 a.m., revealed Resident #5 was in her bed with the fall mat beside the wall. No fall mat was noted beside her bed. CNA R verified the fall mat was beside the wall and not her bed. She said she was her aide but did not realize the mat was beside the wall and not beside her bed. She said she was aware Resident #5 was at risk of falling because her family had informed her.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/29/25 at 3:20 p.m., ADON F said Resident #5 was supposed to have a fall mat beside her bed. She said the staff was responsible for ensuring the fall mat was beside her bed. She said the fall mat was supposed to be beside Resident #5's bed for safety.</p> <p>During an interview on 01/29/25 at 3:50 p.m., the DON said Resident #5 was supposed to have a fall mat beside his bed because she had a fall and was at risk for further falls. She said the nursing staff was responsible for ensuring the fall mat was beside her bed. She said the fall mat was for fall prevention and to prevent an injury.</p> <p>During an interview on 01/29/25 at 4:21 p.m., the Administrator said if Resident #5 had a care plan for a fall mat to be at her bedside, then nursing staff was responsible for ensuring it was beside her bed. She said this resident might have had a fall prior and this was put in place to reduce any injury from further falls.</p> <p>Record review of the facility policy titled, Fall Management System, dated 02/19/21 indicated, It is the policy of this facility that each resident will be assessed to determine his or her risk for falls, and a plan of care implemented based on the resident's assessed needs. A fall occurs when there is an unintentional coming to rest on the floor, ground, or other lower level. A fall without injury is still a fall. Procedure: A, Identifying: #3. A care plan is implemented for residents at risk profile B., Analysis: #5 Preventative interventions are reviewed, evaluated, and implemented to reduce the reoccurrence of falls. E, Investigation: #2 Interventions will be implemented in an attempt to prevent the resident from sustaining further falls. Based on the investigation results, the licensed nurse will initiate intervention measures as soon as practicable such as chair alarm, low bed, etc</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879</p> <p>Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 2 of 5 residents (Resident's #27 and Resident #290) reviewed for respiratory care.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure staff followed the policy for dating the oxygen tubing and bagging the CPAP (a machine that uses mild air pressure to keep breathing airways open while you sleep) on 01/27/25 and 01/28/25 for Resident #27. 2. The facility failed to ensure staff followed the policy for bagging and dating Resident #290's Handheld nebulizer on 01/27/25 and 01/29/25. <p>These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care.</p> <p>Finding included:</p> <p>1. Record review of Resident #27's face sheet, dated 01/29/25 indicated she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included Respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), Dementia (memory loss), and diabetes.</p> <p>Record review of Resident #27's significant change in condition MDS assessment, dated 12/12/24, indicated Resident #27 was understood and usually understood by others. The MDS assessment indicated she had a BIMS score of 07 indicating she was severely cognitively impaired. Resident #27 required assistance with bathing, toileting, dressing, bed mobility, personal hygiene, and eating. The MDS indicated she required oxygen.</p> <p>Record review of Resident #27's physician's order dated 09/09/24 indicated Change oxygen tubing and humidifier bottle every Sunday night and ensuring the tubing was dated when changed.</p> <p>Record review of Resident #27's physician's order dated 10/08/24 indicated Apply oxygen at 2-3 Liter per minute via nasal cannula.</p> <p>Record review of Resident #27's physician's order dated 10/08/24 indicated CPAP at night with settings 5 expiratory pressure, and 15 inspiratory pressures at bedtime for sleep apnea (cessation of breathing) related to acute respiratory failure with hypoxia (inadequate supply of oxygen to the body's tissues).</p> <p>Record review of Resident #27's comprehensive care plan, dated 08/08/24, indicated Resident #27 required oxygen therapy routinely or as needed related to ineffective gas exchange secondary to respiratory illness. The intervention of the care plan was for staff to administer oxygen as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #27's comprehensive care plan, dated 11/20/24, indicated Resident #27 Refuses CPAP at night at times and takes off the mask at night. The intervention was for staff to continue to encourage the resident to wear her CPAP mask.</p> <p>During an observation on 01/27/25 at 10:01 a.m., revealed Resident #27 was in her bed with her eyes closed. Resident #27 had oxygen tubing on the back of her wheelchair bagged but not dated and her CPAP mask sitting on the bedside table not bagged.</p> <p>During an observation on 01/28/25 at 9:05 a.m., revealed Resident #27 was in her bed with her eyes closed. Resident #27's CPAP mask was sitting on the bedside table not bagged.</p> <p>2. Record review of Resident #290's face sheet, dated 01/29/25 indicated a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Dementia (loss of memory), anxiety (a persistent worry, fear, and nervousness that can interfere with daily life), and sleep disorder (a medical condition that affects how well a person sleeps).</p> <p>Record review of Resident #290's admission MDS assessment, dated 01/26/25, indicated Resident #290 understood others and was understood by others. Resident #290's BIMS score was 09, which indicated she was moderately cognitively impaired. The MDS indicated Resident #290 required assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and set-up for eating. The MDS during the 7-day look-back period did not indicate Resident #290 was receiving handheld nebulizers.</p> <p>Record review of Resident #290 physician's orders dated 01/27/25 indicated, Albuterol Sulfate Inhalation Nebulization Solution (2.5MG/3ML) 0.083% (Albuterol Sulfate) 1 dose via mask every 6 hours as needed for shortness of breath.</p> <p>Record review of Resident #290 physician's orders dated 01/28/25 indicated, Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally three times a day for cough/shortness of breath for 3 Days.</p> <p>Record review of Resident#290's care plan dated 01/20/24 did not indicate any plan of care for handheld nebulizers.</p> <p>During an observation on 01/27/25 at 10:18 a.m., revealed Resident #290 had her handheld nebulizer sitting on the nightstand not bagged or dated.</p> <p>During an observation and interview on 01/29/25 at 2:38 p.m., LVN P verified Resident #290's HHN was sitting on the bedside table undated or bagged. He said he had given Resident #290 a breathing treatment earlier but did not ensure the HHN was placed back in a bag. He said the HHN should be dated and bagged when not in use.</p> <p>During an interview on 1/29/25 at 3:50 p.m., the DON said she expected oxygen and HHN tubing to be dated and bagged when not in use. She said the CPAP mask should be bagged when not in use. She said the nursing staff should ensure the items were dated and the tubing bagged, and the administrative nurses should make rounds to ensure the items were dated and bagged. She said they should be bagged to prevent infection control issues.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/29/25 at 4:21 p.m., the Administrator said oxygen and HHN tubing should be bagged and dated. She said the nurses needed to ensure they were changed, dated, and bagged when not in use. She said those things were done to prevent infection.</p> <p>Record review of the facility policy titled, Oxygen Administration dated 09/12/14 indicated, Policy: to describe methods for delivering oxygen to improve tissue oxygenation. Completion of procedure: #2 When oxygen is not in use, store oxygen tubing and nasal cannula or mask in a small plastic bag. #3 Change disposable parts once a week and label with a date (tubing plastic bag mask or Cannula).</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929</p> <p>Based on observation, interview, and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 5.56%, based on 2 errors out of 36 opportunities, which involved 2 of 6 residents (Resident #37 and Resident #80) reviewed for medication administration.</p> <ol style="list-style-type: none"> The facility failed to administer Resident #37's eye drops ophthalmic solution 0.05% Tetrahydrozoline HCL medication (used for temporary treatment of eye redness and irritation.) as ordered. The facility failed to administer Resident #80's Aspirin chewable 81mg medication (used to help prevent a heart attack or clot-related stroke) as ordered. <p>These failures could place residents at risk for not receiving the intended therapeutic benefit of their medications or receiving them as prescribed, per physician orders.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Record review of Resident #37's face sheet, dated 01/28/25, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included intracranial injury (damage to the brain caused by an external force), and hemiplegia (a medical condition characterized by paralysis or weakness on one side of the body). <p>Record review of Resident #37's quarterly MDS assessment, dated 01/15/25, indicated he had a BIMS score of 03, which indicated severe cognitive impairment. He did not exhibit behaviors of rejection of care or wandering.</p> <p>Record review of Resident #37's physician's orders, dated 01/28/25 indicated this order:</p> <p>*Eye Drops Ophthalmic Solution 0.05% Tetrahydrozoline HCL. Instill 1 drop in both eyes in the morning for dry eyes. The start date was 10/23/24.</p> <p>Record review of Resident #37's MAR for January 2024, dated 01/28/25, indicated the eye drops tetrahydrozoline HCL were not administered on 01/28/25. The MAR gave a reason code of 9 which indicated other / see nurse notes.</p> <p>Record review of Resident #37's progress notes, dated 01/28/25, indicated a note written by Medication Aide G that stated:</p> <p>Eye Drops Ophthalmic Solution 0.05% Instill 1 drop in both eyes in the morning for dry eyes[.] Med is not in the [building] but has been ordered</p> <p>During an observation and interview on 01/28/25 at 7:33 AM, Medication Aide G did not administer</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Willow Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 Whippoorwill Kilgore, TX 75662	
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #37's eye drops medication. Medication Aide G said she did not have the eye drops on her cart. She said the drops have been ordered from the pharmacy, but they have not yet been delivered to the facility. She said she notified the nurse that she was unable to give the eye drops. She said the medication would likely be delivered that evening.</p> <p>2. Record review of Resident #80's face sheet, dated 01/28/25, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die) and intracardiac thrombosis (a condition where a blood clot forms within the heart chambers).</p> <p>Record review of Resident #80's quarterly MDS assessment, dated 11/27/24, indicated he had a BIMS score of 15, which indicated intact cognition. He did not exhibit behaviors of rejection of care or wandering.</p> <p>Record review of Resident #80's physician's orders, dated 01/28/25, indicated this order:</p> <p>*Aspirin low dose oral tablet chewable 81mg. Give 1 tablet by mouth in the morning for heart health. The start date was 08/22/24.</p> <p>Record review of Resident #80's MAR for the month of January 2025, dated 01/28/25, indicated he was administered the Aspirin 81mg medication on 01/28/25.</p> <p>During an observation on 01/28/25 at 7:45 AM, Medication Aide G administered aspirin 81mg Enteric Coated 1 tablet to Resident #80.</p> <p>During an interview on 01/28/25 at 3:41 PM, Medication Aide G said she did not realize she had given the enteric coated form instead of the chewable form of the aspirin. She said she did not think there was a risk to the resident because of him receiving the wrong form. She said she should have given the chewable tablet that was ordered.</p> <p>During a group interview with both ADONS on 01/29/25 at 1:27 PM, ADON E said she expected the eye drops medication to have been ordered and available for the resident to have. ADON E said she expected the medication aides to administer the correct form of the aspirin medication. ADON F said the risk to the resident was that the resident was not receiving the benefit of the medication if they are not administered it.</p> <p>During an interview on 01/29/25 at 1:40 PM, the DON said she expected the staff to have the medication needed on the cart and to let someone know so they can get it in the building if they do not have stock of the medication. she said she expected the med aide to give the proper form of the medications.</p> <p>During an interview on 01/29/25 at 1:48 PM, the Administrator said her expectation was that the residents get their medications as ordered and in the form they were ordered. She said the risk would be that the resident did not get the intended benefit of the eye drops when it was not administered.</p> <p>During an interview on 01/29/25 at 3:43 PM, the DON said they do not have a policy for ordering medications.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy, Medication - Treatment Administration and Documentation, last revised on 02/02/14, stated:</p> <p>.Medication are administered according to manufacturers guidelines unless otherwise indicated by physician order .</p> <p>.Process</p> <ol style="list-style-type: none"> 1. Verify labels accurately reflect the physician orders on the Medication Administration Record (MAR) and Treatment Administration Record (TAR) prior to administering patient medications and treatments 2. Verify administration accuracy by checking the medication with the MAR three (3) times 3. Verify and provide medication or treatment focused assessment .as indicated by manufacturers guidelines or physician orders 4. Administer the medication according to the physician order .

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929</p> <p>Based on observations, interviews, and record review, the facility failed to ensure in accordance with state and federal laws, all drugs and biologicals were stored in locked compartments for 1 of 21 residents (Resident #56) reviewed for storage of medication.</p> <p>The facility failed to securely store medications, Resident #56 had a white cream and green powder substances found at her bedside inside medicine cups.</p> <p>These failures could place residents at risk for adverse reactions to medications or overdose.</p> <p>Findings included:</p> <p>Record review of Resident #56's face sheet, dated 01/29/25, indicated she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included chronic diastolic heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively), osteoarthritis (common type of joint disease that causes pain, stiffness, and swelling in the joints), and dementia (a syndrome characterized by a progressive decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life and activities).</p> <p>Record review of Resident #56's quarterly MDS assessment, dated 12/19/24, indicated she had a BIMS score of 15 which indicated intact cognition. Resident #56 did not exhibit behaviors of rejection of care or wandering.</p> <p>Record review of Resident #56's physician's orders, dated 01/29/25, indicated an order for apple zinc oxide barrier cream under breast and abdominal folds for yeast prevention every 12 hours as needed. The start date was 02/28/24. The orders also indicated an order for nystatin external cream, apply to affected areas topically every 12 hours as needed for yeast. The orders did not contain a medication that matched the green powder. There were no wound care orders in the physician's orders.</p> <p>During an observation and interview on 01/27/25 at 9:31 AM, Resident #56 was lying in bed in her room. There was 1 medicine cup that had a white cream substance and 1 medicine cup that had a green powder substance at the bedside. Resident #56 said the cream and green powder were for a wound on her bottom. She said the staff sometimes leave it on her bedside or in the bathroom so she can use it.</p> <p>During an observation on 01/27/25 at 11:35 AM, the medicine cup of a white cream substance and the medicine cup of a green powder substance were still at Resident #56's bedside.</p> <p>During an observation on 01/27/25 at 2:16 PM, the medicine cup of a white cream substance and the medicine cup of a green powder substance were still at Resident #56's bedside.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/29/25 at 1:27 PM, ADON E said she did not expect the staff to leave the medication at her bedside. ADON E said the risk was that someone could ingest the medication or have a potential adverse reaction to the medication. ADON E said she was not sure what the medications were.</p> <p>During an interview on 01/29/25 at 1:40 PM, the DON said she never expects medications to be left at the bedside. She said the risk was that another resident could ingest the medication. She said the medications also should have been labelled.</p> <p>During an interview on 01/29/25 at 1:48 PM, the Administrator said she expected the medications to not be left at the bedside. She said she did not feel there was a risk to the residents because of the medication at the bedside.</p> <p>Record review of the facility's policy, Medication Storage, dated 01/20/21, stated:</p> <p>Policy:</p> <p>It is the policy of this facility to ensure all medications housed on our premises will be stored, dated and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .</p> <p>.1. General Guidelines:</p> <p>a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.</p> <p>b. Only authorized personnel will have access to the keys to locked compartments</p> <p>c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45810</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in 1 of 1 kitchen reviewed for food safety requirements.</p> <p>The facility failed to prepare fried eggs with pasteurized eggs.</p> <p>The facility failed to ensure the kitchen staff had an operable paper towel dispenser to wash their hands instead of placing the paper towel roll on the clean dish rack.</p> <p>The facility failed to ensure the Dietary Manager in training and the [NAME] Helper properly performed hand hygiene while assisting with preparing resident meals in the kitchen.</p> <p>These failures could place residents at risk for foodborne illness.</p> <p>Findings included:</p> <p>1. During an observation on 01/27/24 at 8:45 AM, the refrigerator had 2 (30 count) flats and 1/3 of a (30 count) flat of large white eggs. The white eggs did not have the P stamped on the eggs indicating pasteurized eggs.</p> <p>During an interview on 01/27/25 at 8:50 AM, the Dietary Manager said she prepared the orders in the kitchen and had the pasteurized eggs on a do not substitute list and she did not realize they received the unpasteurized eggs.</p> <p>During a record review and interview on 01/28/25 at 9:35 AM, the Dietary Manager provided the dietary cards for the residents who ate fried eggs. The listing indicated there were 8 residents who received fried eggs. The Dietary Manager said the unpasteurized eggs should not be used in the kitchen. The Dietary Manager said using the unpasteurized eggs could make the residents sick.</p> <p>Record review of a grocery delivery listing dated 01/21/25 provided by the DM on 01/29/25 indicated the facility received one box with 15 dozen eggs (large grade AA white) that were substituted because the vendor was out of the pasteurized eggs.</p> <p>During an interview on 01/29/25 at 3:53 PM, ADON E said her expectation was for the kitchen to only serve pasteurized eggs. She said the kitchen was responsible for ensuring they only had pasteurized eggs and it placed the residents at risk for infection.</p> <p>During an interview on 01/29/25 at 4:33 PM, the DON said her expectation was for the kitchen to not use any unpasteurized eggs and the failure placed the residents at a risk for infection. The DON said the Dietary Manager was responsible for ensuring the eggs were correctly ordered as unpasteurized.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/29/25 at 4:51 PM, the Administrator said the Dietary Manager was responsible for ensuring the residents received unpasteurized eggs. She said the Dietary Manager should have ensured the correct unpasteurized eggs were received. The Administrator said she would be checking for the correctly ordered eggs. The Administrator said the failure placed the residents at risk for infection from the bacteria in eggs or allergies.</p> <p>2. During an observation on 01/27/25 at 11:43 AM, the Dietary Manager in training washed her hands and turned the faucet off prior to grabbing her paper towels that were hanging on top of a clean dish rack to dry her hands. When she grabbed the paper towels water splashed on the clean dishes.</p> <p>During an observation on 01/27/25 at 11:58 AM, [NAME] Helper L washed his hands for less than 20 seconds and turned the faucet off prior to grabbing paper towels that were hanging on top of a clean dish rack to dry his hands prior to preparing resident trays for lunch. When he grabbed the paper towels water splashed on the clean dishes.</p> <p>During an observation on 01/28/25 at 9:35 AM, the Dietary Manager said she had asked the previous administrator, but the paper towel holder was never replaced. She said she understood the paper towel being placed on the clean rack was a risk for infection for the residents.</p> <p>During an interview on 01/28/25 at 9:44 AM, [NAME] L said the paper towel holder had been broken for months. She said the Dietary Manager had always enforced proper handwashing but the previous Administrator told her the broken paper towel holder was not in their budget.</p> <p>During an interview on 01/29/25 at 3:58 PM, ADON E said the paper towel holder being broken was unacceptable and should have been in working order and used correctly. She said that places a risk for infection control. ADON E said the dietary staff were responsible and should have notified the need for correct paper towel or purchase a new paper towel dispenser.</p> <p>During an interview on 01/29/25 at 4:30 PM, the DON said her expectation was for the kitchen to have a properly working paper towel holder to use for hand washing and to perform handwashing properly. The DON said she was not aware that the paper towel holder was broken but the staff and nursing administration were responsible for ensuring the staff were washing hands correctly. The DON said the failure placed a risk for infection for all residents.</p> <p>During an interview on 01/29/25 at 4:54 PM, the Administrator said she expected the equipment to be working properly. She said the Maintenance Director and the Dietary Manager were responsible for ensuring the paper towel holder were operable. The Administrator said the failure placed a risk for infection control.</p> <p>3. During an observation on 01/27/25 at 11:43 AM, the Dietary Manager in training washed her hands and turned the faucet off prior to grabbing her paper towel to dry her hands.</p> <p>During an observation on 01/27/25 at 11:58 AM, [NAME] Helper L washed his hands for less than 20 seconds and turned the faucet off prior to grabbing paper towel to dry his hands prior to preparing resident trays for lunch.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 01/28/25 at 9:42 AM, [NAME] Helper L washed his hands for less than 20 seconds and turned the faucet off prior to grabbing paper towel to dry his hands. [NAME] Helper L said he realized he washed his hands improperly and he thought he was supposed to wash his hands for 2 minutes. He then began to wash his hands again and turned the faucet off prior to grabbing his paper towel to dry his hands. He said the last time he had handwashing proficiency was during a COVID outbreak, but he guessed he was washing his hands correctly. He said the failure could place resident at risk for germs being passed and infections.</p> <p>During an observation and interview 01/28/25 at 9:50 AM, the Dietary Manager in training washed her hands and turned the faucet off prior to grabbing paper towels to dry her hands. She said she had just realized what she was doing and just got in a hurry and forgot. She said she did recall improperly washing her hands on 01/27/25. The Dietary Manager in training said the failure could cause infections to residents.</p> <p>During an interview on 01/29/25 at 3:55 PM, ADON F said she expected proper handwashing to be performed in the kitchen by all staff. She said the Dietary Manager and Nursing Management were responsible for ensuring staff wash their hands properly. The ADON F said the failure placed a risk is for infection and germs to be shared to all residents.</p> <p>During an interview on 01/29/25 at 4:30 PM, the DON said her expectation was for the kitchen to perform handwashing properly. She said the kitchen staff and nursing staff were responsible for ensuring they were washing hands correctly. The DON said the failure placed a risk is for infection for all residents.</p> <p>During an interview on 01/29/25 at 4:55 PM, the Administrator said handwashing performed properly was expected by all staff. She said the Nursing management (DON and ADONs) were responsible for ensuring all staff performed proper handwashing. The Administrator said the failure placed a risk for all resident to get infections and germs.</p> <p>Record review of the facility policy Food Safety and Sanitation Plan revised on 11/2017 indicated:</p> <p>Policy: It is the policy of this facility to follow an effective, proactive food safety program that is based on preventing food safety hazards before they occur .Basis of Control .2. Receiving-When food, food products or beverages are delivered to the facility, the staff will inspect items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated. Delivery will be checked against the purchase order .Eggs may be received at 45 degrees or below and shall be pasteurized .</p> <p>13. Personal Hygiene Practices-through hand washing is required .</p> <p>Record review of FDA Food Code 2022 Chapter 2. Accessed on 02/11/2025 at 11:20 AM indicated:</p> <p>Management and Personnel</p> <p>2-103.11 Person in Charge.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The PERSON IN CHARGE shall ensure that: (D) EMPLOYEES are effectively cleaning their hands, by routinely monitoring the EMPLOYEES' handwashing .</p> <p>Hands and Arms</p> <p>2-301.12 Cleaning Procedure .food employees shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or amrs for at least 20 seconds .</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929</p> <p>Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 3 of 8 resident personal refrigerators reviewed for food safety (Resident #62, Resident #61, and Resident #56).</p> <ol style="list-style-type: none"> The facility failed to ensure the refrigerator for Resident #62 did not contain expired milk. The facility failed to ensure the refrigerator in Resident #61's room did not contain expired strawberry yogurt. The facility failed to ensure the refrigerator for Resident #56 did not contain expired baked beans and expired macaroni and cheese. <p>This failure could place resident at risk for food borne illnesses.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Record review of Resident #62's face sheet, dated [DATE], indicated she was an [AGE] year-old female, admitted to the facility originally on [DATE], and readmitted on [DATE]. Her diagnoses included dementia (a syndrome characterized by a progressive decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life and activities), and biliary acute pancreatitis (a condition where the pancreas becomes inflamed due to gallstones). <p>Record review of Resident #62's significant change MDS assessment, dated [DATE], indicated she had a BIMS score of 0, which indicated severe cognitive impairment. She did not exhibit behaviors of rejection of care or wandering. She required moderate assistance with some activities of daily living.</p> <p>During an observation on [DATE] at 09:11 AM, Resident #62 was in her room lying in bed resting. There was 1 container of expired whole milk (dated [DATE]) in her refrigerator.</p> <p>During an observation on [DATE] at 02:18 PM, the container of expired whole milk was still in Resident #62's refrigerator.</p> <ol style="list-style-type: none"> Record review of Resident #61's face sheet, dated [DATE], indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included dementia (a syndrome characterized by a progressive decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life and activities), major depressive disorder (common mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life), and Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior). <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #61's quarterly MDS assessment, dated [DATE], indicated his BIMS score was 13, which indicated intact cognition. He did not exhibit behaviors of rejection of care or wandering. He was independent with all of his activities of daily living, except for bathing, which he required set-up assistance.</p> <p>During an observation and interview on [DATE] at 09:21 AM, Resident #61 was lying in bed in his room watching TV. He said the refrigerator in the room is his roommate's, who was out of the facility in the hospital. He said no one has looked at the refrigerator in a while. There was 1 expired strawberry yogurt (dated [DATE]) in the refrigerator.</p> <p>During an observation on [DATE] at 02:15 PM, the refrigerator in Resident #61's room still had the expired strawberry yogurt in the refrigerator.</p> <p>During an observation on [DATE] at 09:00 AM, the refrigerator in Resident #61's room still had the expired strawberry yogurt in the refrigerator.</p> <p>3. Record review of Resident #56's face sheet, dated [DATE], indicated she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included chronic diastolic heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively), osteoarthritis (common type of joint disease that causes pain, stiffness, and swelling in the joints), and dementia (a syndrome characterized by a progressive decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life and activities).</p> <p>Record review of Resident #56's quarterly MDS assessment, dated [DATE], indicated she had a BIMS score of 15 which indicated intact cognition. Resident #56 did not exhibit behaviors of rejection of care or wandering.</p> <p>During an observation on [DATE] at 09:31 AM, Resident #56 was lying in bed in her room watching TV. Inside the refrigerator next to her bed there was 2 containers of expired baked beans (1 dated [DATE] and 1 dated [DATE]), and 1 container of expired macaroni and cheese (dated [DATE]).</p> <p>During an observation on [DATE] at 11:35 AM, all three expired containers of food were inside Resident #56's refrigerator.</p> <p>During an observation on [DATE] at 02:16 PM, all three expired containers of food were inside Resident #56's refrigerator.</p> <p>During an observation on [DATE] at 09:02 AM, all three expired containers of food were inside Resident #56's refrigerator.</p> <p>During a group interview with both ADONs on [DATE] at 01:27 PM, ADON F said she expected the staff to go through the resident fridges and throw away the expired food. ADON E said the risk was that the residents could potentially get sick from the expired food. ADON E said the receptionist was responsible for throwing away the expired foods. ADON E said she expected the CNAs to also check the refrigerators. ADON F the usual receptionist was not working this day.</p> <p>During an interview on [DATE] at 01:40 PM, the DON said she expected the staff to check the fridges for expired food. She said the risk was that ingestion of expired food could cause sickness.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Willow Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 Whippoorwill Kilgore, TX 75662	

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 01:48 PM, the Administrator said she expected the staff to clean the fridges and throwaway the expired food. She said the risk to the residents was that they may get sick if the expired foods were consumed.</p> <p>Record review of the facility's policy, Resident Refrigerators, last revised [DATE], stated:</p> <p>.Dormitory-sized refrigerators are allowed in a resident's room under the following conditions:</p> <ol style="list-style-type: none"> a. The refrigerator is inspected by maintenance personnel and deemed safe prior to use b. The refrigerator maintains proper temperatures. c. Sufficient space exists in the resident's room to accommodate the refrigerator without requiring the use of extension cord or multi-plug adapter. d. The resident complies with the facility's policy for use of the refrigerator . <p>.Staff shall inspect the refrigerator weekly, clean as needed, and discard any foods that are out of compliance .</p> <p>.Foods with use-by dates shall be discarded accordingly .</p> <p>.Noncompliance with safety and sanitation requirements of this policy will result in the removal of the refrigerator from the resident's room .</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810</p> <p>Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 5 residents (Resident #54) reviewed for hospice services.</p> <p>The facility failed to obtain Resident #54's most recent updated hospice medication profile to indicate Resident #54 was taking Lorazepam (an antianxiety medication) 1mg tab scheduled every 12 hours scheduled instead of every 4 hours as needed.</p> <p>This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs.</p> <p>Findings included:</p> <p>Record review of Resident #54's face sheet dated 01/29/25 indicated he was an [AGE] year-old male who originally admitted to the facility on [DATE] with the diagnoses dementia (a general decline in cognitive abilities that affect's a person ability to perform ADLs), cerebral infarction (disrupted blood flow to the brain), high blood pressure, attention to gastrostomy tube, and malnutrition (lack of nutrients in the body).</p> <p>Record review of Resident #54's annual MDS dated [DATE] indicated resident was rarely understood and rarely could understand others. The MDS also indicated he had a BIMS score of 0 and had short-term and long-term memory problems. The MDS indicated he required total assistance from staff for all ADLs and required 51% or more of his calories through a feeding tube.</p> <p>Record review of Resident #54's care plan revised on 10/16/24 indicated he had a terminal illness and was receiving hospice services with interventions to coordinate with hospice to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met.</p> <p>Record review of Resident #54's hospice binder on 01/29/25 at 09:37 AM indicated the last medication profile was printed on 08/05/24.</p> <p>Record review of Resident #54's EMR on 01/29/25 at 11:04 AM, indicated the hospice medication record and the facility's physician order did not match. The following order was noted on the facility's order summary report and not in Resident #54's hospice medication record:</p> <p>1.Lorazepam Oral Tablet 1 MG (Lorazepam) Give 1mg via G-Tube every 12 hours for Anxiety / Yelling Out related to ANXIETY DISORDER, UNSPECIFIED</p> <p>Record review of Resident #54's hospice medication record dated 08/05/24 indicated he had an order for:</p> <p>(continued on next page)</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Lorazepam (ATIVAN) 1MG tab; Give 1 tablet by gastrostomy tube every 4 hours as needed for anxiety for 367 days dated 12/19/23-12/19/24.</p> <p>During an interview on 01/29/25 at 03:47 PM, ADON F said the hospice nurse should bring the paperwork when they visit and keep the paperwork updated for the facility staff. ADON F said the failure placed a risk for the lack of communication and changes in care.</p> <p>During an interview on 01/29/25 at 04:25 PM, the DON said her expectation was for the most updated information to be kept in Resident #54's hospice binder. She said the hospice staff were responsible and the charge nurses and nursing administration (DON and 2 ADONs) should be looking at the binders to ensure they are being updated. The DON said the failure placed a risk for medications given that were not ordered or the hospice chart having incorrect information.</p> <p>During an interview on 01/29/25 at 04:44 PM, the Administrator said her expectation was for the hospice nurse to come in and ensure they bring the updated paperwork and the nursing staff at the facility were responsible for ensuring the paperwork is updated as well. She said the failure placed a risk to the resident was a potential for harm due to the medications not matching.</p> <p>Record review of the facility Coordination of Hospice Services Policy revised 03/12/2022 indicated:</p> <p>Policy:</p> <p>When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>1. The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care.</p> <p>2. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the extent possible.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643</p> <p>Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 20 residents (Resident #47, Resident #5, and Resident #54) reviewed for infection control practices.</p> <p>The facility failed to ensure latex gloves, resident's clothes, briefs, and wet clothes were not left on the floor of the resident #47's room .</p> <p>The facility failed to ensure Resident #54's gastrostomy tube piston syringe was properly changed out and covered in the provided plastic bag on 01/27/25 and 01/28/25.</p> <p>The facility failed to ensure RN S wore a gown when she flushed and disconnected Resident #5 gastrostomy tube (also known as a G-tube, is a thin, flexible tube inserted through the abdominal wall directly into the stomach used to provide nutrition and medications directly to the stomach when a person is unable to eat or drink adequately by mouth).</p> <p>These failures placed residents at risk for cross contamination and infection.</p> <p>Findings include:</p> <p>1. Record review of a face sheet dated 07/24/24 revealed Resident #47 was an [AGE] year-old female admitted on [DATE] with diagnoses including Dementia (a general term for a group of brain conditions that cause a decline in mental abilities), Muscle Weakness (a loss of muscle strength that makes it difficult to move or contract muscles), Hypothyroidism (A condition in which the thyroid gland doesn't produce enough thyroid hormone).</p> <p>Record review of an admission MDS dated [DATE] revealed Resident #47 was understood and understood others. The MDS revealed Resident #47 had a BIMS (cognitive/mental status) of 02 which indicated severe cognitive impact. The MDS indicated Resident #47 needed assistance with most activities of daily living.</p> <p>Record review of a care plan initiated on 10/26/2023 and revised on 11/17/2023 revealed Resident #47 had an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner.</p> <p>During an observation on 1/27/25 at 10:28 a.m., Resident #47's room had latex gloves that had been doffed appropriately, as if they had been used in a procedure, laying on the floor, folded clothes stacked on top of each other laying on the floor with a clean disposable adult brief laying open next to them, and a pile of wet clothes in the bathroom floor. Resident #47 was unable to be interviewed by surveyor.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/29/25 at 1:29 p.m., CNA A said that used personal protective equipment, including gloves, should not be left on the floor of a resident's room. She said there were trashcans and biohazard trashcans to throw away used personal protective equipment depending on how it was used. She said clothes and adult briefs are not to be left on the floor they should be stored in cabinets or dressers. She said that clothes should not be left on the floor of the resident's restroom as they too have an appropriate place to store them before they are sent to laundry. She said the clothes would be bagged and stored in a plastic bin. She said residents could be placed at risk for infection if they came into contact with soiled personal protective equipment, briefs, or clothes.</p> <p>During an interview on 1/29/25 at 1:37 p.m., LVN B said that all personal protective equipment should go into a trashcan once it has been used. She said clean clothes should be stored in cabinets or drawers. She said that clean briefs should not be stored on the floor. She said that there is a risk for infection when used personal protective equipment, clothes, and briefs were left on the floor.</p> <p>During an interview on 1/29/25 at 2:04 p.m., the Director of Nursing said used personal protective equipment goes into a biohazard bag or a trashcan. She said facility policy says to keep trash picked up including personal protective equipment. She said clean clothes and briefs goes into the resident's cabinets. She said dirty clothes are to be bagged by CNAs and sent to laundry. She said residents could be placed at risk of infection if they come into contact with used personal protective equipment or dirty clothes. She said there is a risk of contaminating clothes and clean briefs if they are just left on the floor. She said it was all staff's responsibility to ensure that resident's rooms were clean, and they were not exposed to infection risks.</p> <p>During an interview on 1/29/25 at 2:12 p.m., the Administrator said based on her experience personal protective equipment that had been used in a procedure goes into a biohazard bag or trashcan depending on how it was used. She said that personal protective equipment is not disposed of by staff on the floor. She said clean clothes are stored in the dresser drawer as well as the briefs. She said residents could be placed at risk for infection if they came into contact with used personal protective equipment.</p> <p>45810</p> <p>2. Record review of Resident #54's face sheet dated 01/29/25 indicated he was an [AGE] year-old male who originally admitted to the facility on [DATE] with the diagnoses dementia (a general decline in cognitive abilities that affect's a person ability to perform ADLs), cerebral infarction (disrupted blood flow to the brain), high blood pressure, attention to gastrostomy tube, and malnutrition (lack of nutrients in the body).</p> <p>Record review of Resident #54's annual MDS dated [DATE] indicated resident was rarely understood and rarely could understand others. The MDS also indicated he had a BIMS score of 0 and had short-term and long-term memory problems. The MDS indicated he required total assistance from staff for all ADLs and required 51% or more of his calories through a feeding tube.</p> <p>Record review of Resident #54's care plan revised on 10/06/23 indicated he required the use of a feeding tube with interventions to administer tube feeding and water flushes as ordered.</p> <p>Record review of Resident #54's order summary report as of 01/29/25 indicated he had an order for:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Change and date piston syringe every night shift for feeding tube with a start date of 11/28/2023 and no end date.</p> <p>Record review of Resident #54's administration record dated January 2025 indicated LVN U signed the record for changing and dating the gastrostomy syringe on 01/26/25.</p> <p>During an observation on 01/27/25 at 09:29 AM, Resident #54 was lying in bed and had his gastrostomy tube piston syringe lying on his bedside table unbagged and dated 1/26/25 at 0600 with white sediment in the tip.</p> <p>During an observation on 01/27/25 at 02:39 PM, Resident #54's gastrostomy tube piston syringe was lying on the bedside table uncovered and no bag in site and continued to have white sediment in the tip.</p> <p>During an observation on 01/28/25 at 09:06 AM, Resident #54's gastrostomy tube syringe was lying on bed side table dated 1/28/25 but laying outside the plastic bag.</p> <p>During an interview on 01/29/25 at 03:50 PM, ADON F said her expectation was for the night nurse to have changed and dated the piston syringe and all nurses should have rinsed the gastrostomy piston syringe after use, placed in the plastic bag and hang it properly. ADON F said the failure placed Resident #54 at risk for infection.</p> <p>During an interview on 01/29/25 at 04:28 PM, the DON said her expectation were for the gastrostomy piston syringes to be changed out every night by the night nurses and bagged and dated. The charge nurse should always keep the syringes in the plastic bag and the charge nurses were responsible for ensuring the gastrostomy piston syringe was kept in the bag. The DON said the failure placed a risk for Resident #54 to get an infection because the gastrostomy piston syringe was not rinsed or properly contained.</p> <p>During an interview on 01/29/25 at 04:49 PM, the Administrator said the night nurses should have been following doctor's orders and the gastrostomy piston syringe should have been changed out, dated, and bagged daily. She said the failure placed the risk for infection.</p> <p>During a telephone interview on 01/29/25 at 05:23 PM, LVN U said she thought she changed out the piston syringe for Resident #54. She said it must have been misplaced. She said the failure placed a risk for Resident #54 to have bacterial build up in the syringe and cause infections.</p> <p>45879</p> <p>3. Record review of Resident #5's face sheet, dated 01/29/25 indicated she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Dysphagia (swallowing difficulties), dementia (loss of memory), stroke, anxiety (feelings of worry, fear, unease, and apprehension), and diabetes (when your blood sugar is too high).</p> <p>Record review of Resident #5's annual MDS assessment, dated 11/04/24, indicated Resident #5 sometimes understood and was sometimes understood by others. Resident #5's BIMS score was 00 indicating her cognition was severely impaired. The MDS indicated Resident #5 required extensive assistance with her ADLs. The MDS indicated she had a feeding tube.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #5's Physician order dated 04/09/24 indicated: Enhanced barrier precautions in place every shift.</p> <p>Record review of Resident #5's Physician order dated 05/25/24 indicated: Glucerna 1.2 via tube feeding (gastrostomy tube) at 60 milliliters per hour x 22 hours.</p> <p>Record review of Resident #5's comprehensive care plan dated 04/02/24 indicated, Resident #5 required Enhanced Barrier Precautions related to her feeding tube. The intervention was for staff to wear gowns and gloves during high-contact resident care activities.</p> <p>During an observation on 01/28/25 at 9:37 a.m., Resident #5 had a sign for Enhanced Barrier Precautions also known as EBP which indicated they recommended staff to wear gowns and gloves while providing care for any resident who had any of the following: 1) infection or 2) a wound or indwelling medical device, even if the resident was not known to be infected, above her bed.</p> <p>During an observation on 01/28/25 at 9:46 a.m., RN S came into Resident #5's room flushed and disconnected her gastrostomy tube without wearing a gown.</p> <p>During an interview on 01/28/25 at 4:06 p.m., RN S said she flushed and disconnected Resident #5's gastrostomy tube but did not put on the proper PPE. She said she was supposed to wear a gown and gloves, but she only wore gloves. She said Resident #5 was on EBP because of the risk of getting infected.</p> <p>During an interview on 1/29/25 at 3:50 p.m., the DON said she expected staff to follow the precautions for EBP. She said she had given several in-services on infection control. She said staff should wear gloves and gowns when giving meds or flushing a gastrostomy tube. She said she expected RN S to wear her gown and gloves when flushing Resident #5's gastrostomy tube. She said she was responsible for ensuring all staff wore the required PPE. She said Resident #5 was at risk of infection because she had an opening to her skin (gastrostomy).</p> <p>During an interview on 01/29/25 at 4:21 p.m., the Administrator said all staff were responsible for following the infection control practices. She said she expected the nurse to wear the proper PPE such as a gown and glove when in a resident's room who required EBP. She said they would have to do another in-service and monitor for proper PPE usage. The administrator said if they were not wearing the appropriate PPE then they could spread germs or infection to someone else.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility policy titled, Infection Control Plan: Overview, from the Infection Prevention and Control Program revised 11/6/24, indicated, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Policy Explanation and Compliance Guidelines: 2. All staff are responsible for following all policies and procedures related to the program. 4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted while providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies. 6. Enhanced Barrier Precautions (EBP) are used in conjunction with standard precautions and expands the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: a. Infection or colonization with an MDRO when Contact Precautions do not otherwise apply b. Wounds and/or indwelling medical devices (e.g., central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. During high-contact resident care activities: 12. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent the spread of infection. b. Clean linen shall be always separated from soiled linen. e. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the linen shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom.</p>		