STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676365	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Park Rehabilitation and Care Center	300 Crowne Point Blvd Willow Park, TX 76087

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observation, interview, and record review the facility failed to provide services with reasonable accommodation of needs for 1 (Resident #3) of 10 residents reviewed for resident call system. The facility failed to provide a working communication system on 10/01/2024 that was easily at reach and that would allow Resident #3 the ability to safely call for staff for assistance. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they need support for daily living. The findings included: Record review of Resident #3's face sheet dated 10/03/2024, revealed: an [AGE] year-old-female admitted on [DATE], with the following diagnosis Hemiplegia and Hemiparesis following Cerebral infraction right dominant side(weakness and paralysis to right side due to stroke), Atrial Fibrillation(irregular heart rate), Type 2 Diabetes, lack of coordination, . Record review of Resident #3's Quarterly MDS dated [DATE] revealed the following: *Section C- Cognitive Patterns revealed Resident #3 did not have a BIMS score completed due to resident was rarely/never understood. *Section GG- Functional Abilities and Goals revealed Resident #3 was dependent on staff for all ADL's. *Section J Health Conditions revealed Resident #3 had a history of falls. Record review of Resident #3's Care Plan dated 09/05/2024 revealed Resident #3 had a history of falls, and an intervention was for the call light to be in reach. During an observation on 10/01/2024 at 10:30 AM Resident #3 was lying in her bed in her room, the call light was lying in the floor out of Resident # 3's reach. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/01/2024 at 10:50 AM LVN A stated Resident #3 had a soft touch call light. LVN A stated Resident # 3 did not really know how to push the call light for assistance. LVN A stated Resident #3's call light was flat and had a sensor that when Resident #3 moved would alert staff that Resident #3 was trying to move, and staff could respond to prevent Resident #3 from having a fall. LVN A stated Resident #3 should have had call within reach. During an interview on 10/02/2024 at 10:10 AM LVN B stated Resident # 3 should have had her call light within reach. During an interview on 10/03/2024 at 11:45 AM the DON stated her expectation was that call lights should have been placed in reach and attached to the bed, blanket, or chair, to prevent from falling out of reach. The DON stated the effect on residents if call light were not placed within reach could have caused residents to fall if trying to get up to toilet themselves. The DON stated all staff were responsible to monitor the placement of call lights. The DON stated she did not what led to failure of call light no being in place, but stated staff may not have been paying attention. During an interview on 10/3/2024 at 12:30 PM the CD stated expectation was that call lights should have been placed within reach of residents. The CD stated the effect on residents was it could have prevented them to call for assistance. The CD stated that everyone that walks in the room was responsible to ensure the call light was in reach of residents. The CD could not provide a reason to what led to failure of the call light not being within reach of the resident. Record review of facility policy titled, Call Lights: Accessibility and Timely Response dated 01/01/2024 revealed: Staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed .Providing access to assistive devices . Installing longer cords or providing remote controlled overhead or task lighting so that they are easily accessible.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on interview and record review, the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the discharge was necessary for 1 (Resident #1) of 4 residents reviewed for discharge requirements. The facility failed to ensure Resident #1 was provided a discharge in writing with appropriate reason for the necessity of discharge. This failure placed residents at risk of not receiving necessary care and services. Findings included: Record Review of Resident #1's Face Sheet dated 10/03/2024, revealed a [AGE] year-old male, admitted to the facility on [DATE], discharged on [DATE] with the following diagnoses Insomnia, Intellectual Disabilities and Depression. Record review of Resident #1's Admission MDS dated [DATE] revealed: Section C- Cognitive Patterns Resident #1 had a BIMS score of 5, meaning severe cognitive impairment. Record review of Resident #1's progress notes revealed the following: *09/25/2024 at 8:15 AM written by LVN Aindicated Resident has been wandering in and out of other residents room collecting their personal items when trying to redirect resident ,resident states that all items belong to him, this nurse received report from night shift nurse stating that resident has had no sleep and been wandering the halls all night, resident has taken some of his room mates personal items placing them with his things, this nurse reported to DON of building about residents behavior, DON went into residents room to assess resident upon doing so, window was notice with blinds open and window up but screen still intact, resident was not in room staff started looking for resident, became aware that resident had gotten out of facility through window, and had went across street, resident was brought back to facility by [city] police, resident is now one on one with staff, family was notified resident will continue to be monitored. *09/25/2024 at 6:14 PM written by the social worker indicated Per the incident this morning, SW contacted [Resident #'1] [family members] to request that they take him home tonight. SW will continue to find alternative placements for him. Record review of Resident #1's Transfer/Discharge Report dated on 09/25/2024, and signed by Resident #1's family representative, revealed no evidence of why Resident #1 was discharged from the facility. During an interview on 10/01/2024 at 10:50 AM LVN A stated Resident #1 had not been exit seeking and had not been aggressive to other resident or staff. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/02/2024 at 10:30 AM Resident # 1 family representative stated he was called to come get Resident #1 on 09/25/2024 and was not given a reason to why except that Resident #1 had eloped from the building that morning. Resident #1 family representative stated he and a family member were not in good health and could not take care of Resident #1. Resident #1 family representative stated Resident #1 stated he loved the facility and did not want to leave. During an interview on 10/03/2024 at 11:27 AM the SW stated she and the MDS coordinator were responsible for discharges. The SW stated when it was determined a discharge was necessary, she was responsible to make referral to locate alternative placements or ensure that services were in place if going home, arrange transportation and make sure nursing had put orders in chart to ensure medications were ready to be sent home. The SW stated what initiated an immediate discharge was if the facility felt they could no longer meet a resident's needs. The SW stated if residents were eloping, they might need a facility that had a secure unit and they would discharge once they located a facility for the resident to go to. The SW stated she had made some referrals for Resident #1 that day but could not locate a facility to take him that day, so they contacted family to pick Resident #1 that day because they did not want him to escape again. The SW stated the ADMN was the one who stated Resident #1 needed to be discharged that day. The SW stated there was no change in medical condition that warranted him to be discharged , and that they could have continued to do one on ones until a new placement could be located. The SW stated she did not feel the family was given appropriate time to find a new facility and stated family were elderly and were not able to properly take care of resident. The SW stated in her previous experience family should have been given a letter of discharge and also given at least 24 hours. The SW stated she had never encountered a discharge happening same day. During an interview on 10/03/2024 at 11:45 AM the DON sated the facility does not usually do an immediate discharge. The DON stated an immediate discharge would be given due to safety of resident. The DON stated if residents were exit seeking, she would start the conversation about starting to looking for another appropriate facility, especially if they had gotten out of the facility. The DON stated the only interventions that were done after the elopement was Resident #1 was placed on one on ones once until family picked him up. The DON stated there had not been a change in Resident #1's medical condition that the facility was not able to provide appropriate care. During an interview on 10/03/2024 at 12:30 PM the CD stated his expectation was that if a resident was a danger to self or others that would warrant and an immediate discharge as soon as possible. The CD stated the facility should attempt to find alternative placement. The CD stated he was a part of the conversation to discharge Resident #1. The CD stated Resident #1 discharge was appropriate because he was at risk of getting out a window again and it would have been unwise to keep him at the facility. The CD stated Resident #1 was his own decision maker, on admission he was informed that if he wanted to leave to let them know. The CD stated Resident # 1's BIMS score was not a good indicator on his ability to make decisions that it was one tool of many tools used to assess. The CD stated the resident was not aggressive to staff or other residents. The CD stated the elopement piece was what changed the medical needs they could no longer provide for. The CD stated they did not have the staff to do one on ones with resident. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled, Transfer and Discharge (including AMA) dated 1/1/24 revealed: once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following species exemptions: A. The transfer discharge is necessary for the residents welfare and the residents needs cannot be met in the facility. B. The transfer or discharge is appropriate because the residents health has improved sufficiently so the resident no longer needs the services provided by the facility. C. The safety of individuals and the facility is in danger due to the clinical or behavioral status to the resident. D. The health of individuals in the facility would otherwise be endangered. E. The resident has failed, after a reasonable and appropriate notice, to pay or have paid under Medicare or Medicaid for his or her stay at the facility. Nonpayment applies if the resident it's not submit the necessary paperwork for the third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her state. F. The facility ceases to operate.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46641 Based on interview and record review the facility failed to develop and implement an effective discharge planning process that focused on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmission for one of four residents (Resident #1) reviewed for discharge planning. 1. The facility failed to implement discharge plan for Resident #1 who was admitted on [DATE] until the day he was discharged on [DATE] . 2. The facility failed to notify the Ombudsman of Resident #1's discharge. 3. The facility failed to notify Resident #1's physician of the discharge. These failures could place residents at risk of not having their care needs addressed after discharge. Findings include: Record review of Resident #1's face sheet, dated 10/18/24, reflected [AGE] years-old male who was admitted to the facility on [DATE]. Record review of Resident #1's physician's admission notes, dated 09/10/2024, reflected Resident #1 had Intellectual disability, history of substance abuse, depression with anxiety, and mood disorder. Record review of Resident #1's care plan, dated 09/30/2024 , reflected Resident #1's care plan did not address discharge planning. Record review of Resident #1's Admission MDS Assessment, dated 09/17/24, reflected Resident #1's BIMS score was 5, which indicated the resident had severe cognitive impairment. Resident #1 had symptoms of depression. Resident #1 had no symptom of delirium, psychosis or behaviors. Resident #1 had no impairment to upper or lower extremities and needed limited set-up or clean-up assistance to eat, toilet, bathe, dress, or personal hygiene. No special treatments or programs needed. Resident #1 participated in his assessment and goal setting. Resident #1's overall goal was to remain in the facility. Active discharge planning for the resident to return to the community had not yet begun. No referrals were made to a local contact agency because the referral was not wanted. In an interview on 10/18/2024 at 10:25 AM with Resident #1's responsible party stated he was notified by the facility's SW of Resident #1's desire to discharge and was asked to meet at the facility to talk about possibly taking Resident #1 home. At the meeting on 09/25/24 at 11:00 AM the family member stated the DON, Administrator, SW, Resident #1, and him were in the facility's conference room. The family member stated he agreed to take Resident #1 home. The family member stated he received Resident #1's medications with written and verbal instruction and that was it. The family member stated he did not receive any Discharge notice from the facility. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/21/2024 at 1:10 PM, the SW stated she was responsible for discharges, and notifying ombudsman, physician, and any care services if resident required. The SW stated she tried to contact the Ombudsman by phone to notify them of the discharge but, was not able to speak to Ombudsman but left a message. The SW stated she did not notify Resident #1's primary physician and did not provide Resident #1 or the family with a Discharge notice or written reason for discharge. The SW stated the discharge happened so quick she did not have time to follow the facility's Discharge procedures. The SW stated she discharge happened quickly because Resident #1 wanted to leave that day. In an interview on 10/21/2024 at 3:15 PM, Resident #1's primary physician stated he was not notified of discharge . Physician stated he is generally notified of any of his resident's discharge. In an interview on 10/23/2024 at 3:30 PM, the Ombudsman stated she was not notified of the resident's discharge and did not receive a phone call or message from the facility or the facility's SW on 09/25/2024. In an interview on 10/23/2024 at 1:48 PM, the DON stated the SW was responsible for resident discharges. The DON stated after the meeting with Resident #1's family, they agreed to take the resident home and she had nothing else to do with the discharge . In an interview on 10/24/2024 at 1:43 PM, by phone, (Previous Administrator working at facility on 09/25/2024 but no longer employed at facility) stated she, the DON and SW had meeting with Resident #1 and his family on 09/25/24 at 11:00 AM. The Administrator stated it was decided Resident #1 would go home with family. The Administrator stated the SW was responsible for discharge. The Administrator stated the SW was to notify the Ombudsman, physician and provide written notice of discharge to the resident and the family. The Administrator stated not following policy and procedure could affect resident's care while in the community. Record review of the Transfer and Discharge policy, dated: 01/01/2024, reflected the following: Policy .4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all the following at the time it is provided: a. The specific reason and basis for transfer or discharge. b. The effective date of transfer or discharge. c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged . d. An explanation of the right to appeal the transfer or discharge to the State. e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests. f. Information on how to obtain an appeal form. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. Information on obtaining assistance in completing and submitting the appeal hearing request. h. The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman. i. For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice will include the name, mailing and e-mail addresses and phone number of the state agency responsible for the protection and advocacy of these populations.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 44722 Based on interviews and record reviews, the facility failed to ensure staffing information was posted in a prominent place readily accessible to residents and visitors that included: The total number and the actual hours worked by the registered nurses, licensed practical nurses or licensed vocational nurses and certified nurse aides directly responsible for resident care per shift for 21 of 21 days reviewed for required postings. The facility failed to ensure the daily staffing information was posted in a prominent location on 10/02/2024. This failure could place residents, their families, and visitors at risk of not knowing how many staff are currently working to provide care on all shifts. Findings Included: During an observation on 10/02/2024 at 11:40 AM, the daily staffing posted in hallways was dated 09/11/2024. During an interview on 10/02/2024 at 11:45 AM, the DON stated her expectation was that the daily staffing be posted daily. The DON stated a previous employee was responsible for posting the daily staffing and when she left, she had not realized that it was not being posted. The DON stated it was now her responsibility. The DON stated she did not think there was a negative effect to residents. During an interview on 10/03/2024 at 12:30 PM the CD stated his expectation was that the daily staffing should have been posted every day per regulation. The CD stated the ADMN was responsible to monitor and ensure it was posted. The CD stated he did not feel there was a negative effect on residents. The CD stated what led to failure was lack of the DON and ADMN following up to ensure the daily staffing was posted. Review of policy titled Nurse Staffing Posting Information dated 01/01/2024 revealed: It is the policy of this facility to make staffing information readily available in a readable format to residents and visitors at any given time . The nurse staffing sheet will be posted on a daily basis.