

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Willow Park Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Crowne Point Blvd Willow Park, TX 76087	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident receives care to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates they were unavoidable and a resident with pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing for 1 (Resident #3) of 3 residents reviewed for pressure ulcers/wounds.</p> <p>The RN B failed to provide wound care for Resident #3's unstageable pressure ulcer to the right buttock and unstageable pressure ulcer to her right lateral foot on the date of 04/12/25.</p> <p>This deficient practice could place residents at risk for worsening pressure injuries, pain, and a decline in health.</p> <p>Findings included:</p> <p>Review of Resident # 3's electronic face sheet reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: leg fracture, dementia, and mild protein calorie malnutrition (nutritional state in which reduced availability of nutrients leads to changes in body composition and function).</p> <p>Review of Resident # 3's Admission MDS assessment dated [DATE] reflected Resident #3 had a BIMS score of 04 indicating severe cognitive impairment. Further review of Section M reflected resident was at risk for pressure ulcers and had no pressure ulcers.</p> <p>Review of Resident #3's care plan on 04/12/25 last revised 04/09/25 reflected: Focus: The resident has pressure ulcer development .Unstageable to right buttock (04/02/25) worsened due to favoring right side/declining.</p> <p>Review of Resident # 3's electronic physicians orders dated 04/12/25 reflected: Cleanse pressure injury to right buttocks and right lateral ankle with wound cleanse, pat dry, apply collagen sheet, cover with hydrocolloid dressing, dated 04/03/2025 and Cleanse unstageable pressure injury to right buttock with wound cleanser, pat dry, apply calcium alginate with Santyl, cover with dry dressing, order initiated on 04/9/25.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #3's Initial Wound Evaluation by wound care physician on 04/08/25, reflected an unstageable pressure ulcer to the right buttocks measuring 2.5 cm by 4.0 cm and an unstageable pressure area covered with necrotic tissue measuring 2 cm by 2 cm.</p> <p>Record review of Resident #3's Administration Report on 04/13/25 which was dated 04/1/25 to 04/30/25 revealed, wound care was documented as completed for 04/11/25, and 04/12/25 on the day shift.</p> <p>An observation on 04/13/25 at 1:00 pm revealed Resident # 3 had a dressing to her right buttocks that was dated 04/11/25. Her right foot was covered by a sock. The paid care giver removed the sock from Resident# 3's Right foot and there was no dressing on the foot covering the wound.</p> <p>In an interview on 04/13/25 at 1:05 PM the paid caregiver stated the dressings on the right buttocks and the right lateral ankle was last changed on 04/11/25. The paid caregiver stated she had not told a nurse that Resident # 3's dressing hadn't been changed.</p> <p>During an interview on 04/13/25 at 1: 10 PM , with the DON, who stated wound care was supposed to be done as ordered. The DON stated during the weekday the Treatment Nurse conducts the wound care and on the weekend the nurses are able and have to do the wound care. The DON stated that nurses are trained to look at the orders while gathering the supplies for the wound treatment and cannot be looking at the orders earlier in the day and doing the wound treatment without looking to verify the orders. The ADON stated the risk would be a decline in the resident's wound condition or infection</p> <p>In an interview at 1:30 PM on 04/13/25 with RN B, who stated he worked on 04/12/25 as charge nurse. He stated it was his responsibility to do the wound care for Resident # 3 and he had not done her wound care on 04/12/24. He stated there was no wound care nurse to help on the weekends and he just got busy and forgot. He stated he documented that the treatment was done because he intended to do it. RN B stated that there was not a Wound Care Nurse on the weekend, but all nurses were able to provide wound care. RN B stated the risk of not providing wound care could be the wound getting worse or infection.</p> <p>In an interview on 04/14/25 at 10:45 AM, with the Treatment Nurse, who stated she provided wound care during the weekdays and on the weekend nurses, the nurses were to be providing the wound care. The Treatment Nurse stated the nurses on the weekend would be able to provide wound care for those residents needing wound care. The Treatment Nurse stated she changed Resident #3s dressing to her right buttocks and right lateral ankle on 04/11/25. She stated she did not work on 04/12/25, and that RN B worked that day. She stated a negative outcome that could result in failure to perform treatments at the ordered frequency could be a delay in the wound in healing.</p> <p>In an interview on 04/14/25 at 2:00 PM the Wound Care Doctor stated the nurses were to be providing wound care. The Wound Care Doctor stated these issues of failure to do wound care had not been brought to his attention. The Wound Care Doctor stated he should have been informed of any missed wound care or significant changes but he was not notified. The Wound Care Doctor stated the risks of failure to provide wound care would be deterioration, or infection. He stated failure to do wound care was definitely a problem that needed to be addressed by the DON and she needed to pinpoint where the failure occurred and correct the problem in order to prevent it happening again.</p> <p>Record review of the facility policy titled Skin Management and Pressure Ulcer Prevention, dated 10/11/22, revealed the following [in part]:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, other altered skin integrity, and to provide treatment and services to heal pressure ulcer/injury and/or altered skin integrity, prevent infection and the development of additional pressure ulcers/injuries. It is our policy to perform a full body skin assessment as part of our systemic approach to pressure injury prevention and skin management.</p> <p>1. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.</p> <p>2. Assessment of Pressure Injury Risk</p> <p>a. Licensed nurses will conduct a pressure injury risk assessment, using the Braden Scale on all residents upon admission/re-admission, weekly x four weeks, then quarterly or whenever the resident's condition changes significantly.</p> <p>b. The tool will be used in conjunction with other risk factors not captured by the risk assessment tool. Examples of risk factors include, but are not limited to:</p> <p>i. Impaired/decreased mobility and decreased functional ability:</p> <p>ii. Co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus.</p> <p>iii. Drugs such as steroids that may affect healing.</p> <p>iv. Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency.</p> <p>v. Resident refusal of some aspects of care and treatment.</p> <p>vi. Cognitive impairment.</p> <p>vii. Exposure of skin to urinary and fecal incontinence.</p> <p>viii. Under nutrition, malnutrition, and hydration deficits; and</p> <p>ix. The presence of a previously healed pressure injury.</p> <p>c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record.</p> <p>d. Assessments of pressure injuries and altered skin integrity will be performed by a licensed nurse and documented on the Skin Observation Tool. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task.</p>