

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 05/23/2025
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 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** 46641</p> <p>Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #12 and Resident #13) of thirteen residents reviewed for Reasonable Accommodation of Needs.</p> <p>The facility failed to ensure the call light was in reach and accessible for Resident #12 and Resident #13 on 05/22/25.</p> <p>This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.</p> <p>Findings included:</p> <p>Review of Resident #12's Face Sheet, dated 5/22/25, reflected a [AGE] year-old female, admitted on [DATE]. Resident #12 had diagnoses of, Cerebral infarction (stroke), need for assistance with personal care, vascular dementia (reduced blood flow to brain), muscle wasting (loss of muscle mass).</p> <p>Review of Resident #12's Quarterly MDS Assessment, dated 5/11/25, reflected that Resident #12 had a BIMS score of 3, indicating severe cognitive impairment. The Quarterly MDS Assessment indicated the resident required assistance for toileting, dressing, personal hygiene and transferring.</p> <p>Review of Resident #12's Comprehensive Care Plan, dated 3/13/25, reflected Resident #12 was a fall risk, and one of the interventions was a reachable call light.</p> <p>Observation and interview on 5/22/25 at 11:55am revealed Resident #12 lying in bed. The call light was observed clipped to a power cord of the mini refrigerator located at the foot of Resident #12's bed.</p> <p>Resident #12 stated that she can operate the call light for help if the call light is within reach. Resident #12 pointed to the call light at the foot of her bed and stated she cannot reach that.</p> <p>Review of Resident #13's Face Sheet dated 5/22/25, reflected a [AGE] year-old female, admitted [DATE]. Resident #13 had diagnoses of Dementia (decline in cognitive abilities), malignant neoplasms (cancerous tumors), muscle weakness, history of falling.</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>Review of Resident #13's Quarterly MDS Assessment, dated 3/18/25 reflected that Resident #13 had a BIMS score of 12, indicating moderate cognitive impairment. The Quarterly MDS Assessment indicated that Resident #13 needed assistance with transferring, and toileting.</p> <p>Review of Resident #13's Comprehensive Care Plan dated 4/2/25 reflected that Resident #13 was a fall risk, and an intervention listed was call light within reach.</p> <p>Observation and interview on 5/22/25 at 12:00pm, revealed Resident #13 lying in bed. The call light was laying on the floor under the left side of the bed. Resident #13 stated that sometimes her call light was not within reach. She said staff generally clip it on the bed or handrail, but sometimes she cannot find it when she needs it. Resident #13 stated she did not know where it was now.</p> <p>In an interview on 5/22/25 at 12:07pm, CNA L came into Resident #13's room and stated that she had come from Resident #12's room and placed the call light within reach and then picked up Resident #13's call light and clipped it to her handrail within reach. CNA L stated that call lights need to be within reach for residents, residents that need assistance use the call light, and if residents cannot find or reach the call light, residents could have accidents. CNA L stated that call lights should be always within reach.</p> <p>In an interview on 5/22/25 at 12:15pm, LVN M stated that call lights are to be always within reach for residents, and staff are to make sure when they monitor and provide care, before they leave, the call light is within reach.</p> <p>In an interview on 5/23/25 at 3:05pm, Administrator stated it was his expectation that call lights were to be always within reach for residents, and staff were to make sure when they monitor and provide care, before they leave, the call light is within reach. Incidents can happen if residents cannot call for assistance when needed.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46641</p> <p>Based on observation, interview, and record review the facility failed to ensure it was adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside and toilet and bathing facilities for 2 of 2 nurse's stations (Hall 100/200 station and Hall 300/400 station).</p> <p>Resident's emergency call light was not audible at either the Hall 100/200 or Hall 300/400 nurse's stations.</p> <p>This failure placed residents at risk of not receiving timely care/assistance, falls, fall related injuries, head trauma, and hospitalization .</p> <p>Findings included:</p> <p>During observation on 5/23/25 at 5:00am, surveyor was standing at the nurse's station for Halls 100 and 200. Surveyor observed the call light outside of room [ROOM NUMBER] flashing but there was no audible sound at the nurse's station. Surveyor observed that at nurse's station for Halls 300 and 400 the call light system did not submit an audible when the call light was activated from room [ROOM NUMBER].</p> <p>During an interview on 5/23/25 at 5:06am, LVN CC stated he has worked at the facility for 1 year, on Halls 100 and 200, and the audible system worked when he first started but stated that the audible sound at the nurse's station has not worked in a while. He said he did not recall when it stopped working. LVN CC stated that administration knew it was not working and the maintenance person was working on repairing until the maintenance person quit working at the facility. LVN CC stated he did not know who was working on it now. LVN CC stated that having an audible sound at the nurse's station would help staff on recognizing when a resident needed assistance.</p> <p>During an interview on 5/23/25 at 5:15am, CNA DD stated he has worked at the facility for 2 months. CNA DD stated that he knew to answer call lights by observing the room lights flashing. He said there was no audible sound for the call lights since he has worked here. CNA DD stated it would help if there was an audible sound to go with the light flashing when residents used the call light.</p> <p>During an interview on 5/23/25 at 5:30am, LVN G stated she has worked at the facility for 6 months, on Halls 300 and 400. LVN G stated the call light audible system has not worked since she has worked here.</p> <p>LVN G stated that it would help a lot if they had an audible sound along with the light flashing outside of resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 5/23/25 at 10:30am, the Administrator stated the call light system should have a flashing light outside the resident's room and be accompanied by sound at the nurse's station so that if staff could not see a call light request, they could hear it to ensure residents received timely help after pushing their call light. The Administrator stated that without sound the call light system placed residents at risk of falls, not having needs met, food aspiration and then stated, there are so many things that could go wrong if the call lights did not have a sound . The Administrator stated the facility did not have documentation that the call system was routinely maintained or tested by the maintenance department.</p> <p>Record review of the facility's policy titled Resident Call System,, dated September 2022, revealed Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation . The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard.</p>		