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	04/09/2025

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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 44722 Based on interviews and record reviews, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property for 2 of 15 employees (MM and CNA B) reviewed for employability. The facility failed to ensure record of criminal history check and/or an EMR/NAR check prior to offering employment were maintained. These findings placed residents at risk of receiving care by someone that was unemployable. The findings included: Record review of MM's employee file revealed a hire date of 07/22/2024 and no evidence of criminal history or an EMR check were completed prior to offering employment. Record review of CNA B's employee filed revealed a hire date of 08/08/2024 and no evidence of criminal history check or a NAR check were completed prior to offering employment. During an interview on 04/09/25 at 02:25 PM the DON stated she was not able to locate the criminal history and EMR/NAR check for MM and CNA B. The DON stated that there has been turn over in the HR position and does not know what had happened to the criminal history and EMR/NAR checks. During an interview on 04/09/25 at 2:45 PM HR stated she had been at this position since February. HR stated she was responsible to complete the criminal history and EMR/NAR checks. HR stated criminal history and EMR/NAR checks should have been completed prior to hiring and kept in the employee file. HR stated she had looked and was not able to locate MM and CNA B's background checks and was not sure why they were not there. During an interview on 04/09/25 at 03:21 PM the ADMN stated his expectation was that criminal history and EMR/NAR checks were completed and maintained per stated and federal requirements, for employees prior to employment. The ADMN stated HR was responsible for completing criminal history EMR/NAR checks. The ADMN stated he monitored background checks being completed monthly and but had only been monitoring for the new hires. The ADMN stated the affect on residents could have been the potential of residents being exposed to someone who could have done them harm. The ADMN stated he felt the checks had been completed but were misplaced. The ADMN stated what led to the failure was staff turnover, in HR position and the Administrator position. (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy titled, Background Screening Investigations dated March 2019 revealed: 1. For purposes of this policy direct access employee means any individual who has access to a resident or patient of a long term care (LTC) facility or provider through employment or through a contract and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the state for purposes of the national background check program. 2.The director of personnel, or designee, conducts background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on all potential direct access employees and contractors. Background and criminal checks are initiated within two days of an offer of employment or contract agreement and completed prior to employment. 3. For any individual applying for a position as a certified nursing assistant, the state nurse aide registry is contacted to determine if any findings of abuse, neglect, mistreatment of individuals, and/or theft of property have been entered into the applicant's file.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on observation, interview, and record review the facility failed to conduct an accurate assessment for 1 (Resident #47) of 18 residents reviewed for assessments. The Facility failed to ensure Resident # 47 most recent MDS dated [DATE] was accurately completed with Resident's hospice status, who was receiving hospice care. These failures could place residents at risk by decreasing the accurate information available to determine the care and services needed for each resident. The findings included: Record review of Resident # 47's face sheet dated 04/09/2025 revealed a [AGE] year-old female admitted on [DATE] with the following diagnoses heart failure, high blood pressure, and chronic kidney disease. Record review of Resident #47's Quarterly MDS dated [DATE] revealed: Section C- Cognitive Pattern- Resident had a BIMS of 7, meaning moderate cognitive impairment; Section O- Special Treatments, Procedures, and Programs revealed no evidence Resident #47 received hospice care. Record review of Resident #47's most recent physician orders revealed an active order with a start date of 09/17/2025 Admit to {hospice name} for DX: heart Failure; active order with a start date of 02/13/2025 stated Admit to {hospice name} with a diagnosis of heart failure. Record review of Resident #47's Care Plan dated revealed: Resident was admitted to hospice care on 09/19/2024. Observation on 04/07/2025 at 11:56 AM revealed Resident #47 laying in her bed awake. Resident #47 had equipment with hospice name written on it. During an interview on 04/09/25 at 2:25 PM the DON stated the MDS Coordinators were responsible to complete the MDS. The DON stated her expectation was for MDS' to be completed timely and completely. The DON stated if a Resident was receiving hospice care, then their MDS should reflect they were receiving hospice care. The DON stated Resident #47 had been receiving hospice care. The DON stated they did not have a policy for MDS that they followed the RAI. During an interview on 04/09/25 at 03:10PM MDS C stated she was responsible for completing the Resident # 47's MDS. MDS C stated the MDS should have reflected all the current care areas and services a resident was currently receiving. MDS C stated she had only been one of the MDS coordinators for a few weeks and was still learning. MDS C stated she had forgotten to check the box for hospice care on the MDS but had ensured the care plan and orders had stated hospice. MDS C stated she did not think there was a negative effect on residents because Resident #47 was receiving hospice care. MDS C stated oversight on her part led to failure of hospice not being checked on the MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/2025 at 3:21 PM the ADMN stated his expectation was that the MDS be updated per policy and procedure. The ADMN stated the effect on Residents could have been a potential for inappropriate communication of resident care needs. The ADMN stated the nursing leadership and the ADMN were responsible for monitoring completion of MDS. The ADMN stated miscommunication of the MDS process by nursing leadership led to failure of items being missed on the MDS.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44558 Based on observation, interview and record review, the facility failed to follow the menu for 1 of 1 lunch meals observed. 1.The facility failed to ensure a sufficient amount of vegetables were prepared for residents on a regular diet. 2. The facility failed to ensure residents who were on a regular diet received vegetables that were not pureed. These failures could place residents at risk for dissatisfaction, poor intake, altered nutritional status, choking, and/or weight loss. The findings included: During an observation on 04/07/2025 at 11:00 AM the daily menu posted on wall outside of kitchen revealed: Lunch-Smothered Port Tips, Baby Baker, Fried Cabbage, Cornbread, Cookie, Beverage. During an observation of meal service on 04/07/2025 at 12:15 PM dietary staff ran out of regular cabbage for residents on a regular diet. The dietary staff served 3 resident's trays, who were on a regular diet, pureed cabbage. During an observation on 04/07/2025 at 12:36 PM the requested test tray did not have fried cabbage or pureed cabbage on the test tray. During an interview on 04/07/2025 at 12:45 PM the DM stated she did not usually run out of food. The DM stated she would monitor food line and if she saw an item was running low, she would prepare more of that item in case a resident wanted more of that item. The DM stated some residents would not like to eat a pureed food if they normally ate a regular diet. The DM stated not having enough food or the right consistency could cause residents to not eat and to lose weight. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/09/2025 at 2:23 PM the facility's dietician stated any pureed vegetable, meat, starch should not be served to resident who was on a regular diet. The dietician stated the cook should not have run out of anything that was being served for that meal. The dietician stated the cook should have known how much to cook of each item for meals in case the residents wanted an additional serving. The dietician stated the cook should have made sure she was ordering enough groceries for all meals. The dietician stated a resident who was on a regular diet would probably not eat something that was pureed. The dietician stated a resident on a regular diet would possibly not find a pureed food as appealing and would not eat it. The dietician stated this could have led to weight loss for the resident. The dietician stated she monitored the DM and visits facility 2 times a month and monitored lunch service on her visits. The dietician stated she did not know how this failure occurred. During an interview on 04/09/2025 at 3:30 PM the ADMN stated residents should have been served a diet consistency that was ordered by their physician. The ADMN stated a resident with a regular diet should not have been served a puree vegetable. The ADMN stated the residents might be disinterested in eating the food which could have caused weight loss. The ADMN stated the DM or designee should have monitored to ensure there was enough food with the appropriate consistency. The ADMN stated this failure occurred due to miscalculation of needs for regular diets. Record review of facility's policy titled: Menus and Adequate Nutrition (no date) revealed: The purpose of this policy is to assure menus are developed and prepared to meet resident choices including their nutritional, religious, cultural, and ethnic needs, while using established guidelines. The facility will ensure that menus meet the nutritional needs of the residents in accordance with established national guidelines . Menus will be followed as posted. Notification of any deviations from the menu shall be made as soon as practicable. Substitutions shall comprise of foods with comparable nutritive value The facility's dietician or other clinically qualified nutrition professional will review all menus for nutritional adequacy and approve the menus. 44722

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on interviews and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 18 residents (Resident #74) reviewed for accuracy of records, in that: The facility failed to document in Resident #74's weekly skin assessment dated [DATE], that Resident #74 had a pressure ulcer to her right buttocks discovered on 04/02/25. This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care. The findings included: Review of Resident #74'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 malnutrition. Review of Resident #74's Admission MDS assessment dated [DATE] reflected Resident #74 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. Review of Resident #74's care plan 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. Review of Resident #74's weekly skin assessment dated [DATE], reflected no evidence of a wound to the right buttocks. Review of Resident #74's electronic physicians orders reflected: Cleanse pressure injury to buttocks with wound cleanse, pat dry, apply collagen sheet l, 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, dated 04/09/2025. Review of Resident #74's electronic progress notes reflected: 04/02/2025 2:53 pm noted pressure wound to sacrum measuring 2 by 4 cm, signed by wound care nurse. Review of Resident #74's Initial Wound Evaluation dated 04/08/25, reflected an unstageable pressure ulcer to the right buttocks measuring 2.5 cm by 4.0 cm. During an interview on 04/09/25 at 10:00 AM, the wound care nurse stated the floor nurses were responsible for completing skin assessments and were to notify her of any changes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/25 at 1:45 PM, LVN A she stated she did perform a skin assessment on Resident #74 on 04/08/2025 She stated she did not recall if the resident had a wound to her buttocks or not. She stated that whatever she documented was what she saw. LVN A then stated she must have forgotten and got confused when she completed the skin assessment document and forgot to add the wound. During an interview on 04/09/25 at 03:17 PM, the DON she stated her expectation was for documentation to be completed accurately. She stated she felt the error was from staff not paying attention or not actually doing the skin assessment and just coping the last documentation which was false documentation. She stated all nurses had been repeatedly in-serviced regarding documentation. She stated the negative outcome could be residents would have wounds and they would not get identified or treated which could lead to infection and further skin break down. Review of facility policy titled, Documentation in Medical Record, revised 01/01/24, reflected in part: Policy: Each residents medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the residents progress through complete, accurate, and timely documentation.