STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455416	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Ridge Wellness & Rehabilitation	8001 Western Hills Blvd Fort Worth, TX 76108

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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents had a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely for one (Resident #1) of seven residents reviewed for dignity. 1. Staff failed to ensure Resident # 1 was not laying directly on the sealed protective plastic packaging with her bare skin touching the plastic on 01/29/26. The failure could place residents at risk for skin irritation, poor sleep quality, and suffocation hazards.Findings included: Resident #1Record review of Resident #1's admission record, dated 01/29/26, reflected an [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included sequelae of cerebral infarction (aftereffects of stroke such as memory loss, paralysis, depression and chronic pain, that has impacted daily life and independence), glaucoma in both eye (this is an eye disease that causes vision loss), Congestive heart failure, and Type 2 diabetes (a problem in the way the body regulates and uses sugar as fuel). Resident #1 was her own responsible party. Record review of resident #1's quarterly MDS Assessment, dated 11/10/25 reflected a BIMS score of 8, indicating moderate cognitive patterns. She was always incontinent with bowels and bladder and dependent on staff with toileting, showers, and transfers. The MDS did not indicate any wounds or pressure sore. Record review of Resident #1's care plan, initiated 05/09/25, reflected the following: Focus: [Resident #1] had ADL self-care deficit related to debility [physical weakness]. Goal: To improve/maintain current level of function in all ADLs through the review date 02/17/26. Intervention: Bed mobility: The resident requires extensive assistance by 2 staff to turn and reposition in bed, skin inspection: The resident requires skin inspection every week. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse.' Record review of Resident #1's reentry skin assessment completed on 1/19/26 by RN A, revealed bruising on her right wrist and back of her palm due to an IV. The assessment did not reveal any concerns for pressure wounds. Observation 01/29/26 at 09:33 AM revealed Resident #1 was in bed. Resident #1 was lying on top of the protective plastic packaging of her brand-new mattress. Resident #1's back area with skin exposed was directly touching the plastic as she laid on her back. Resident #1 could communicate well; however, she could not recall the exact times or date that she had been on the plastic packaging of the new mattress. Resident #1 stated Oh that is the sound I hear when I move some. When asked how long she had been on the plastic with her skin exposed on it, she stated God knows how long but my legs are hurting. Resident #1 requested for her legs to be moved, and the call light was activated for staff to assist her. Continuous observation and interview on 01/29/26 at 09:36 AM, revealed RN A came into Resident #1's room and repositioned Resident #1's legs. Resident #1's bare calf area on both legs had been lying flat on the plastic. RN A said that she did not know who had placed the resident on the mattress without removing the plastic cover. She said she was not sure how long she (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been on it. She said when Resident #1 readmitted she was on a regular mattress without the plastic packaging on it. She said failure to remove the plastic packaging placed the resident's skin directly on the plastic and at risk for skin irritation and breakdown and it was not a homelike environment. She said the facility had just received new mattresses but was unsure on the date or who had placed Resident #1 on the new mattress. She stated she would have the packaging removed right away. In an interview with CNA C on 01/29/26 at 09:46 AM, she said Resident #1 had been in the hospital and had been back in the facility for one week. She said she did not know why the person who put Resident#1 on the new mattress did not remove the packaging or extend the bottom sheet so that the resident's skin was not directly on the plastic. CNA C stated some mattresses did not require to have a bottom sheet on them such as air mattress but the one on Resident #1's bed was the actual packaging of the mattress. She said the risk was skin problems. In an interview with CNA D on 01/29/26 at 12:31 PM he said he had been assigned to Resident #1 as her aide. He said he had noticed today at 6:30 AM the mattress was still with the plastic packaging on it but he thought it might have been a specialized type of mattress. He said he did not verify with the nurse because some mattresses came that way and he thought it was part of a compressor bed. He said that the facility worked with different vendors such as hospice and he was not sure when Resident #1 was placed on the new mattress. He stated the risk was rubbing of the skin on the plastic packaging and creating a bed sore. In an interview with the MDS nurse on 01/29/26 at 1:58 PM, revealed Resident #1 was on her angel rounds. She said angel rounds were when department heads went to different residents' rooms and had a one-on-one time with the resident, made sure they had ice water, the call light was working, and they had no immediate concerns. She said that she did not notice that Resident #1 was laying on top of the plastic packaging. She said she did not know how she missed it. She said she had visited Resident #1 after returning from the hospital (1/19/26) and she did not recall Resident #1 on the mattress with the packaging still on it. When the nurse was asked why the packaging was not removed before placing Resident #1 on the bed, she said she could not speak on the actions of others and why they did not remove the plastic packaging. She said the expectation was that the plastic packaging was removed, a fitted or bottom sheet was placed on the mattress prior to putting the resident in bed. She said that the risk to Resident #1 was skin breakdown. Interview with DON on 01/29/26 at 2:42 PM revealed she was not aware of Resident #1 situation of being laid on plastic packaging. She said the expectation was that packaging was removed off the mattress and bed was made up with clean linen. She said the risk to the resident was skin breakdown. She said all nursing staff were responsible. Interview with the Administrator on 01/29/26 at 2:58 PM, she said they had just gotten new mattresses for the facility in the past 4 days. She said she would get the DON to complete a skin assessment on Resident #1. She said the expectation was that the staff would remove the mattresses out of the plastic packaging before placing them on the mattress. She said that she would also start an in-service on the new mattresses because all the residents were getting new mattresses. She said except for Resident 1 all the residents that had already gotten a new mattress did not have the plastic packaging still on. She said she had gone around to check the rooms. She said due to plastic packaging being non-breathable plastic, the risk to the residents was potential skin breakdown. She said all residents had a right to a comfortable environment. Record review of facility policy titled Residents Rooms and Environment revised 08/2020 revealed Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to thefollowing:A. Cleanliness and order;B. Private closet space in each resident room;C. Lighting that is comfortable (minimum glare) yet adequate (suitable to the task);D. Personalized furniture and room arrangements;E. Pleasant, neutral scents;F. Comfortable levels of ventilation;G. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comfortable temperatures; andH. Comfortable noise levels. II. The resident will be provided with a bed of proper size and height for safety and convenienceof the resident.