STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675272	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbend Nursing and Rehabilitation Center	2231 Highway 80 E Mesquite, TX 75150

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46486 Based on interview and record review the facility failed to implement the facility's own written abuse and neglect prevention policy and procedure for one (Resident #32) of six residents reviewed for abuse and neglect. The Administrator failed to immediately suspend one staff member (the CNA) pending investigation when an allegation of physical abuse of Resident #32 was made in a verbal statement by family member on 1/28/25. This failure could place residents at risk of a lack of protection from being abused pending the investigation of an allegation of abuse. Findings included: Review of Resident #32's face sheet reflected an [AGE] year-old male, admitted on [DATE], with diagnoses of Unspecified Sequalae of unspecified Cerebrovascular Disease (neuro-logic deficits that persist after a cerebrovascular accident or stroke), muscle weakness, COVID-19, Cataract, Convulsions, Cerebral Infraction (ischemic stroke, occurs when blood flow to the brain is interrupted, causing brain tissue to die), difficulty in walking, Hyperlipidemia (abnormally high levels of lipids in the blood, including cholesterol and triglycerides), recurrent Depressive Disorders, essential Hypertension, Occlusion and Stenosis of right middle cerebral artery (can occur due to a buildup of plaque in the artery), Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominant side (refers to a stroke (brain tissue damage due to lack of blood flow) that has occurred on the left side of the brain, specifically in the area that control the non-dominant side of the body), and dysphagia (difficulty swallowing). Review of Resident #32's Quarterly MDS Assessment, dated 11/28/24, reflected his sight and hearing were adequate, and he was able to express himself, be understood by others, and to understand others. His BIMS score was 7, indicating severely cognitive impairment. He had no indicators of depression, or psychosis, and exhibited no behavioral problems. Further review of section GG revealed he was dependent on staff for chair/bed-to-chair transfer. Review of the facility January 2025 Grievances revealed that on 01/28/2025 an aide putting Resident #32 to bed was not very gentle. The resolution stated that aide counseled by DON, statement obtained, and training done. Under the satisfied column a yes was placed. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #32's care plan, undated, revealed a focused area, initiated on 01/22/2020, Resident #32 had potential impairment to skin integrity immobility. The goal initiated on 01/22/20, revealed Resident #32 would be free from injury through the review date. The interventions initiated 01/22/20 included to use caution during transfer and bed mobility to prevent striking arms, legs, and hands against any sharp surfaces. During an interview on 02/05/25 at 4:28 PM, the ADON revealed that on 01/28/2025 she was met by the family member of Resident #32 in the hallway, and she reported to her that the CNA was rough with Resident #32 and that he almost fell off the bed during transfer from chair to bed. The ADON stated she walked with the family member back into the room where the CNA had finished changing Resident #32 and the ADON observed the Resident #32 resting peacefully in bed there was no distress. The ADON asked the CNA to leave the room with her and told her she was no longer to work with Resident #32 after that the ADON went and informed the ADM who was with the DON. The ADON told the ADM and DON that the family member reported to her that the CNA was rough with the resident during transfer. The ADON stated the ADM and her left the room and went back to Resident #32 room, she conducted a head-to-toe assessment there was no bruising, skin tears or pain noted and then the ADM asked the resident questions. While the ADM interviewed Resident #32 the ADON left the room to talk to the CNA and asked her what happened and the CNA expressed what was alleged did not happen and then the CNA was moved to different hall. The ADON revealed she and the DON started reeducating the staff that day on the abuse and neglect policy. During an interview on 2/7/25 at 10:33 AM, the DON revealed that she was made aware of alleged abuse of Resident #32 by the ADON. The ADON came to my office on 1/28/25 at unknown time and the ADM was present when ADON entered and stated that Resident 32's family member alleged that she witnessed CNA being rough while she transferred Resident #32 from his chair to bed. The DON went to remove CNA from Resident #35's care but did not conduct an interview with the CNA until next day 1/29/25. The DON stated that the CNA wasn't suspended just moved to different hall. The DON stated the staff member was not suspended because when we conducted our investigation, we did not confirm alleged abuse. The DON stated that when a resident confirmed allegations of abuse that is when the staff member is suspended while they conducted the investigation. During an interview on 2/7/25 at 11:47 AM, the ADM revealed that the ADON immediately reported that Resident #32's family member alleged that a staff member kicked Resident #32 and was rough during his transfer from chair to bed. The ADM stated that the staff member was removed from resident care immediately but was not suspended because Resident #32 stated he didn't feel he had been abused. The ADM said with an allegation of abuse we first interview the resident to see if they feel they were abused, if the resident confirms they feel abused we will suspend the alleged staff member, report it to state, conduct a head to toe assessment and start investigation once investigation complete will submit what we found to state and if unsubstantiated will allow the staff to return to work, but that staff member is not to work with resident anymore. The ADM stated that there was no risk to the other residents because we did not confirm the alleged abuse. The ADM stated that he would have to review the facilities policy for a refresher if staff member had to be suspended if the resident did not confirm the alleged abuse. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/7/25 at 1:16 PM, the Clinical Resource Nurse revealed that she had provided education to the facility and would quiz staff on the types of abuse and procedure of who and when to report an allegation of abuse. The Clinical Resource Nurse stated that when there is an allegation of abuse that involved staff member the facilities policy was to suspend staff member involved immediately pending investigation. The Clinical Resource Nurse stated that the risk to the other resident to allow an alleged perpetrator to work with other residents during investigation would put the risk of the other residents being abused. An interview on 2/7/25 at 2:05 PM with CNA revealed Resident #32 family member was present upon her entry of room and family member requested that Resident #32 be put in bed as he had fell asleep in chair. The CNA stated she had repositioned his chair to assist with transfer of Resident #32 she then stood in front of Resident #32 chair placed her arms under his and lifted him up, but once she lifted Resident #32 his body stiffened up and to prevent both her and Resident #32 from falling she laid the resident on his back across the bed, then she was able to reposition Resident #32 then she changed resident in front of family member. The CNA stated the family member then left the room as she finished cleaning Resident #32 up and then the ADON came into the room and got me and told me and stated that I could not work with Resident #32 any longer the CNA stated she was confused but continued to work. The CNA said that Resident #32 was a one person assist and had never stiffened up during transfer before and she just wanted to prevent the resident from a fall. She stated she decided to lay him across the bed, no part of his body hit the floor and at no point was she rough or kicked the resident during transfer. The CNA said that the DON talked to her the next day (1/29/2025) before she started her shift about what had taken place in Resident #32's room during the transfer and took my statement. The CNA stated that she was not suspended just reeducated on care for residents, to ask for help if needed and switched halls with another aide. Review of the facility Grievance Resolution Form dated 01/28/2025 received by SW on Resident #32 summary statement of the resident's grievance stated CNA was putting resident to bed, was not gentle. The person who reported the grievance was Resident #32's family member. The steps they took to investigate the grievance was SW immediately notified the ADM, investigated, and did not find any signs/forms of abuse. The summary of findings revealed the CNA states this never happened and no injuries or concerns with Resident #32. The corrective action taken as a result of the grievance followed up with family member regarding concern and CNA was removed from Resident #32 section, head to toe assessment done and no finding of abuse and neglect. The ADM signed on 01/29/2025. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation documentation for a family member reported allegation of abuse by a staff member, submitted to the ADM on 1/28/25, reflected Resident #32's family member alleged that a staff member kicked and was rough with Resident #32 while she transferred from chair to bed. In the investigation materials provided, a statement by the ADM, dated 01/28/25 reflected Upon being notified that a complaint had been made by Resident #32's family member concerning about the Resident #32's care, I immediately visited the resident and interviewed him concerning the complaint. I asked if the resident felt like he had been abused and resident responded that he did not. I then asked if Resident #32 had been kicked or thrown off the bed as the family member had reported and the resident again responded that he did not. The resident denied any pain and the ADON stated that she would be doing a skin assessment on the resident as the family member had reported a fall had occurred. The resident denied any allegation of abuse and the resident is able to make his wishes known. I have had multiple interactions with this resident on previous occasions. Additionally, provided was a statement by CNA dated 1/29/25 at 2:14 PM reflected I, CNA assigned to Resident #32 on 1/28/25 2-10 shift, I brought Resident #32's roommate in the room and family member was visiting and asked me to lay resident #32 in the bed due to Resident #32 sleep on chair. Upon transfer Resident #32 leaned and was stiff on transfer laid cross the bed but did not fall or hit any part of the body. I then repositioned resident and changed soiled brief and made resident comfortable. Review of the facility Abuse Prevention Program policy, revision dated October 2022, reflected: G) Protection: 3. If the allegation of abuse, neglect, misappropriation of resident property, or exploitation involves an employee, the facility will: Immediately remove the employee from the care of any resident Suspend the employee during the pendency of the of the investigation.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46486 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse was reported to state agencies no later than 2 hours for one (Resident #32) of six residents reviewed for reporting allegations. The ADM failed to notify officials/state agency of the allegation of abuse regarding Resident #32 being transferred in a rough manner (kicked and thrown in the bed) by CNA on 01/28/2025. This failure placed residents at risk of continued abuse, trauma, and psychosocial harm. Findings included: Review of Resident #32's face sheet reflected an [AGE] year-old male, admitted on [DATE], with diagnoses of Unspecified Sequalae of unspecified Cerebrovascular Disease (neuro-logic deficits that persist after a cerebrovascular accident or stroke), muscle weakness, COVID-19, Cataract, Convulsions, Cerebral Infraction (ischemic stroke, occurs when blood flow to the brain is interrupted, causing brain tissue to die), difficulty in walking, Hyperlipidemia (abnormally high levels of lipids in the blood, including cholesterol and triglycerides), recurrent Depressive Disorders, essential Hypertension, Occlusion and Stenosis of right middle cerebral artery (can occur due to a buildup of plaque in the artery), Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominant side (refers to a stroke (brain tissue damage due to lack of blood flow) that has occurred on the left side of the brain, specifically in the area that control the non-dominant side of the body), and dysphagia (difficulty swallowing). Review of Resident #32's Quarterly MDS Assessment, dated 11/28/24, reflected his sight and hearing were adequate, and he was able to express himself, be understood by others, and to understand others. His BIMS score was 7, indicating severely cognitive impairment. He had no indicators of depression, or psychosis, and exhibited no behavioral problems. Further review of section GG revealed he was dependent on staff for chair/bed-to-chair transfer. Record review of Resident #32's care plan, undated, revealed a focused area, initiated on 01/22/2020, Resident #32 had potential impairment to skin integrity immobility. The goal initiated on 01/22/20, revealed Resident #32 would be free from injury through the review date. The interventions initiated 01/22/20 included to use caution during transfer and bed mobility to prevent striking arms, legs, and hands against any sharp surfaces. Record review of Resident #32's progress notes dated 01/29/25 revealed ADON met Resident 32's family member in hallway who stated resident almost fell on the floor after CNA was rough with transferring him onto the bed. Also, stated the CNA was kicking him on his feet. Upon entering the room observed resident #32 in bed seemingly peaceful without grimace, eyes closed but easily aroused by verbal stimuli. Resident #32 expressed no pain head to toe assessed no injuries noted. Notified responsible party, she stated I already know, a family member called me and said CNA threw him on the bed and he almost fell on to the floor. Expressed to responsible party he is resting in bed peacefully with no injuries. DON, ADM, MD notified. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/05/25 at 4:28 PM, the ADON revealed that on 01/28/2025 was met by the family member of Resident #32 in the hallway and she reported to her that the CNA was rough with Resident #32 and that he almost fell off the bed during transfer from chair to bed. The ADON stated she walked with the family member back into the room where the CNA had finished changing Resident #32 and the ADON observed the Resident #32 resting peacefully in bed there was no distress. The ADON asked the CNA to leave the room with her and told her she was no longer to work with Resident #32 and then went an informed the ADM who was with the DON. The ADON told the ADM and DON that the family member reported to her that the CNA was rough with the resident during transfer. The ADON stated the ADM and her left the room and went back to Resident #32 room, she conducted a head to toe assessment there was no bruising, skin tears or pain noted and then the ADM asked the resident questions, while the ADM interviewed Resident #32 the ADON left the room to talk to the CNA and asked her what happened and the CNA expressed what was alleged did not happen and then the CNA was moved to different hall. The ADON was not sure if the CNA was ever suspended and said that the risk to the residents for staff not to be suspended if the allegation of abuse is true others are at risk of injuries from abuse. The ADON revealed she and the DON started reeducating the staff that day on the abuse and neglect policy. During an interview on 2/7/25 at 10:33 AM, the DON revealed that she was made aware of alleged abuse of Resident #32 by the ADON. The ADON came to my office on 1/28/25 at unknown time and the ADM was present when ADON entered and stated that Resident 32's family member alleged that she witnessed CNA being rough while she transferred Resident #32 from his chair to bed. The DON changed CNA hall on 01/28/25 but did not conduct interview with CNA until next day 1/29/25 before CNA went on floor. The DON stated that the CNA denied all allegation of alleged abuse. The DON stated that when a resident confirmed allegations of abuse that is when the staff reports allegation of abuse to state agency. The DON stated she was not aware if the allegation of abuse had been reported to state agency. The DON stated that reeducation was started on 01/28/25. During an interview on 2/7/25 at 11:47 AM, the ADM revealed that the ADON immediately reported that Resident #32's family member alleged that a staff member kicked Resident #32 and was rough during his transfer from chair to bed. The ADM stated that he immediately went to Resident #32 and asked if he felted abused and Resident #32 responded that he did not feel he was abused or neglected and felt safe in the facility. The ADM stated that the staff member was removed from Resident #32's care. The ADM stated that he did not report the alleged abuse to state agency because Resident #32 stated he did not feel abused. The ADM stated that he would have to review the facilities policy for verification if it stated that it is not required to report to state agency if the resident did not confirm the abuse. Review of the facility Abuse Prevention Program policy, revision dated October 2022, reflected: H) Reporting/Response: 2. Allegation of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy an applicable regulation.