

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Willowbend Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for one (Resident #1) of five residents reviewed for neglect allegations. The facility failed to ensure they reported the FM's concern about the care Resident #1 received at this Nursing Facility. This failure could place all residents at risk if the facility did not follow the HHSC guidelines for reporting allegations resulting in the residents having emotional turmoil and decreased health and psycho-social well-being. Findings included: Record review of Resident #1's admission MDS Assessment, dated 09/13/25, revealed, a [AGE] year old male who admitted [DATE] with a BIMS score of 07 (Severe cognitive impairment). He used a walker and wheelchair for mobility and was dependent on dressing. He needed supervision/ touching assistance with eating, oral and personal hygiene. He needed substantial/maximal assistance with showers and toileting and partial assistance with sitting and standing and transfers. He was occasionally incontinent and not rated for bowel movement. He had diagnoses of atrial fibrillation, renal insufficiency, UTI, DM, CVA, malnutrition, muscle weakness, fatigue, repeated falls, difficulty walking, unsteadiness on feet, other speech/language deficits following CVD, constipation and disorientation. He had rare pain occasionally and had a fall within the last six months prior to admission. And he had two falls since admission with injury except major. Record review of Resident #1's Care Plan, dated 09/11/25, revealed he was at risk for impaired cognitive function or impaired thought processes, at risk for infection related to UTI during recent hospitalization, at risk for ADL self-care performance deficit related to disorientation: CVA Bell's palsy, AMS, UTI, at risk for falls related to history of falls, multiple falls during recent hospitalization, multiple falls during stay with the FM, muscle weakness, unsteadiness on feet fatigue, repeated falls, at risk for pain related to rib fracture, complaints of rib pain during recent hospitalization, at risk for has urinary infection and at risk for altered cardiovascular status related to cardiac pacemaker placement, at risk for atrial fibrillation, at risk for CVA. And at risk for renal insufficiency. Record review of Resident #1's Nurses note dated 09/14/25 at 12:32 pm by LVN C revealed, Resident continues on follow up for PO (by mouth) antibiotic Cefdinir 300 mg (milligram) 1 cap (capsule) for UTI. No adverse drug effects noted. Resident is tolerating the medication well. Continues on fall follow up Day 2/3. Resident is awake, alert and oriented x 2. No s/sx (signs and symptoms) of SOB (Shortness of breath), distress or pain voiced. No delayed injuries. Fall precautions in place, bed in the lowest position, fall mat at bedside. Call light and bed remote within reach. Record review of Resident #1's Nurses note dated 09/14/2025 at 1:24 pm by LVN C revealed, Resident is having right sided weakness and was having difficulty feeding self. Unable to grip his spoon at lunch time to feed himself, vitals taken 127/69, 70, 97.8F, 18, 98% RA (room air). Resident is alert and oriented x 2-3. Speech is clear. Resident was able to eat by [sic] breakfast by himself. Informed the Doctor regarding the weakness. N/O (new order) received from the Doctor to send resident to the hospital for further testing and CAT scan to r/o (rule out) stroke. Informed the FM. Informed the DON. Called EMS to arrange transportation to the hospital. They will arrive here shortly to take resident to the hospital. Interview on 09/14/25 was attempted with Resident #1 but he was at another facility in another town. Interview on 09/25/15 at 3:40 pm, the FM stated Resident #1 went to the hospital 09/14/25. The FM stated on 09/15/25 they went to the facility and told the SW A and ADON B about the nurses not paying attention to Resident #1's change of condition and his falls. The FM stated they were very upset and told SW A and ADON B that the hospital said Resident #1 had more rib fractures. They stated they were upset with LVN C for not sending Resident #1 out sooner than he did 09/14/25 for looking like he had a stroke. They stated feeling the facility knew they had done something wrong because they cancelled Resident #1's care plan meeting scheduled for 09/15/25. They stated they wanted to have Resident #1's care plan meeting anyway, to complain about his care at this facility. Interview on 09/25/25 at 4:05 pm, LVN C stated he was the weekend supervisor 09/14/25 and he saw Resident #1 around 6:00 am, and he was fine and responded normally to him when he asked him questions and he did not have any stroke like symptoms. He stated Resident #1 did not have any falls during his shift but he had fallen twice two days prior and they were doing neuro checks. He stated the FM came to visit late morning</p>		