

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 10/16/2024
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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for 4 (Resident #80, Resident #75, Resident #41, and Resident #84) of 6 resident's bathrooms and for 2 (both shower rooms on redwood hall) of 3 shower rooms reviewed for environment.</p> <ol style="list-style-type: none"> The facility failed to ensure resident's bathrooms were sanitary and clean for Resident #80, Resident #41, Resident #75, and Resident #84. The facility failed to provide a shower curtain for Resident #75. The facility failed to ensure 2 shower rooms were sanitary and clean. <p>These failures could place residents at risk of psychosocial harm and feeling uncomfortable due to living in an environment that was not homelike.</p> <p>Findings included:</p> <p>Record review of Resident #80's Quarterly MDS assessment dated [DATE] revealed Resident #80 was a [AGE] year-old female admitted to the facility on [DATE] with a BIMS score of 08 (suggested moderately impaired cognition) and diagnosis of depression.</p> <p>Record review of Resident #80's care plan revised on 08/02/24 revealed Resident #80 had diagnoses of anxiety, panic disorder, and agoraphobia (fear and anxiety of an unsafe environment).</p> <p>Record review of Resident #75's Quarterly MDS assessment dated [DATE] revealed Resident #75 was a [AGE] year-old male admitted to the facility 11/09/20 with a BIMS score of 15 (suggested cognition intact) and a diagnosis of depression.</p> <p>Record review of Resident #75's care plan revised on 07/23/24 revealed Resident #75 was at risk for falls and an intervention included for this focus was that the resident needed a safe environment with floors free from spills and/or clutter.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #41's Quarterly MDS assessment dated [DATE] revealed Resident #41 was a [AGE] year-old male admitted on [DATE] with a BIMS score of 10 (suggested moderately impaired cognition) and a diagnosis of cerebral infarction (stroke).</p> <p>Record review of Resident #41's care plan revised on 07/30/24 revealed Resident #41 had a potential for a psychosocial well-being problem.</p> <p>Record review of Resident #84's Annual MDS assessment dated [DATE] revealed Resident #84 was a [AGE] year-old male admitted on [DATE] with a BIMS score of 12 (suggested moderately impaired cognition) and a diagnosis of muscle weakness.</p> <p>Record review of Resident #84's care plan revised on 08/04/24 revealed Resident #84 was at risk for falls and an intervention included for this focus was that the resident needed a safe environment with floors free from spills and/or clutter.</p> <p>In an interview on 10/14/24 at 9:40 a.m., Resident #80 stated that her bathroom was dirty, and she did not like it.</p> <p>Observation on 10/14/24 at 9:48 a.m., Resident #80's bathroom had brown splatters and smudges on the grab bar next to the toilet. There were also brown splatters on the wall above the toilet paper holder, a white chalky dry substance on the floor around the toilet and sink, and three dark dried substances approximately four to six inches long on the floor near the toilet.</p> <p>In an interview on 10/14/24 at 9:49 a.m., CNA B stated housekeepers clean the bathrooms daily and was unsure what the brown substances on the handrail and wall were. CNA B also stated the floor in Resident #80's bathroom did not look clean and should be cleaned every day . CNA B reported she would sometimes help clean when she could but usually called housekeeping to clean.</p> <p>In an interview on 10/14/24 at 9:57 a.m., Resident #75 stated his shower curtain was removed because it was dirty about a year ago. Resident #75 reported the shower curtain was never replaced, and he did not like that there was not a shower curtain because water would get everywhere. Resident #75 also stated sometimes his bathroom was dirty, but he was not picky.</p> <p>Observation on 10/14/24 at 9:58 a.m., Resident #75's bathroom had multiple areas on the wall behind the toilet where a liquid had run down and dried. There was a large wet spot on the floor near the toilet that was at least a foot long and a foot wide that had a wet paper towel in the center. There was a white chalky substance on the floor near the wall by the toilet and a black substance around the edges of the shower. There were two quarter size holes near the bottom of the shower and no shower curtain.</p> <p>In an interview on 10/14/24 at 10:05 a.m., Resident #41 stated his room and bathroom were not cleaned like his family member would clean them. Resident #41 did not answer how this made him feel.</p> <p>In an interview on 10/14/24 at 10:07 a.m., Resident #84 stated it bothered him if his environment was not clean and reported that sometimes the bathrooms were clean.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 10/14/24 at 10:08 a.m., Resident #41 and Resident #84's bathroom had urine in the toilet and the wall next to the toilet had stains where a liquid had run down and dried. [NAME] substances were on the top edge of the bathroom trim on the bottom of the wall near the toilet.</p> <p>Observation on 10/14/24 at 10:19 a.m., the shower room on redwood hall across from resident room two had black substances around the edges of the shower, orange residue encircling the bottom half of the shower, and an orange slimy substance on the bottom edges of the shower curtain.</p> <p>Observation on 10/14/24 at 10:30 a.m., the second shower room on redwood hall across from the nurse's station had a large brown splatter on the wood cabinet near the sink.</p> <p>In an interview on 10/14/24 at 10:31 a.m., ADON A entered the second shower room on redwood hall, and stated she did not know what the brown substance was but that it could have been stool.</p> <p>In an interview on 10/14/24 at 10:33 a.m., ADON A entered the shower room on redwood hall across from resident room two, and stated she did not know what the black substance was around the edges of the shower. ADON A also stated that there was a film around the bottom half of the shower, and that it needed to be deep cleaned by housekeeping.</p> <p>In an interview on 10/14/24 at 2:39 p.m., the Housekeeping Supervisor reported that he monitored resident's bathrooms and shower rooms for cleanliness every day. The Housekeeping Supervisor reported sometimes the bathrooms needed cleaned more than one time a day because four people were using them. The Housekeeping Supervisor reported he had a deep cleaning schedule and stated rooms were deep cleaned when residents changed rooms or moved in or out. The Housekeeping Supervisor reported an unclean environment was not a risk to the residents.</p> <p>In an interview on 10/15/24 at 9:02 a.m., the ADM stated the Housekeeping Supervisor was responsible for monitoring the cleanliness of the resident's bathrooms and shower rooms. The ADM reported that the resident's rooms and bathrooms were cleaned every day and all staff were responsible for reporting if an area was dirty. When asked how the residents may feel, the ADM stated that you wouldn't want to live in a dirty house, so it needed to be cleaned.</p> <p>Record review of the facility's policy titled Resident Rights with an amended date of 07/13/17, stated You have a right to a safe, clean, comfortable and homelike environment.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50445</p> <p>Based on observation, interview and record review, the facility failed to ensure all assistive devices were maintained and free of hazards for one (Resident #73) of three residents reviewed for essential equipment.</p> <p>The facility failed to properly maintain the bedside commode for Residents #73.</p> <p>This failure could place residents at risk for equipment that is in unsafe operating condition, which could cause injury.</p> <p>Findings included:</p> <p>Review of Resident #73's quarterly MDS assessment dated [DATE], reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Dementia (confusion and forgetfulness), coronary artery disease (narrowing or blockage of heart arteries), Peripheral Vascular Disease (narrowed or blocked blood flow to the arms or legs), Diabetes (alteration in blood sugars), and Unsteadiness on Feet, in part. Resident #73 had a BIMS score of 11 indicating moderate cognitive impairment. Further review of section GG revealed she was frequently incontinent of bowel and bladder and able to independently transfer to the toilet.</p> <p>Review of Resident #73's plan of care dated 09/04/24 reflected interventions included the need to monitor Resident #73's extremities for signs and symptoms of injury, infection, or ulcers due to her Peripheral Vascular Disease.</p> <p>In an observation on 10/14/24 at 03:00 p.m., a bedside commode was noted sitting above the toilet in Resident #73's bathroom. The bedside commode was noted in significant disrepair with extensive rusting and paint loss on all the metal bars.</p> <p>In an interview and observation on 10/15/24 at 03:50 p.m., Resident #73 was noted in her bathroom sitting on the bedside commode above the toilet. This was the same bedside commode noted on 10/14/24 and it remained in significant disrepair with extensive rusting and paint loss. The back of Resident #73's legs and her hands were noted in contact with the metal areas missing paint and covered in rust. Resident #73 was interviewed and stated that the bedside commode had been covered in rust since she was admitted to the facility about two years ago. She stated she had not reported it as a concern because she had not known she could say anything about it to staff. She stated the condition of the bedside commode had been bothering her and that it would be nice if something had been done about it. She denied having experienced any abrasion or injury related to the bedside commode and none were observed.</p> <p>In an interview on 10/15/24 at 04:10 p.m., LVN C stated he had worked for the facility for three months on evening shift. When shown Resident #73's bedside commode LVN C stated, It needs a new one. I will have to reach out to maintenance. He put a glove on and felt of one area on the bedside commode with missing paint and stated, It's not sharp but it is rusty.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/15/24 at 02:00 p.m., Maintenance Supervisor D stated that he and one other maintenance personnel were responsible for replacing any equipment in disrepair. He stated that the maintenance department did not make rounds on equipment such as bedside commodes, but that they had relied on nursing to report the concern to them using the maintenance binder found at each nurse's station. He denied having had any knowledge of a complaint about a bedside commode being in disrepair. He reported that if rust were found on bedside commodes, they were thrown in the trash and not repaired, but replaced instead. He reported that although he was not medical personnel, he imagined that rust and loss of paint on a bedside commode could hurt a resident.</p> <p>In an interview and observation on 10/15/24 at 04:15 p.m., ADON A when shown Resident #73's bedside commode, stated she would get it replaced. She immediately removed it from resident use and stated she would get another from supply. When asked about potential resident harm she stated, I'm OCD so that would have driven me crazy.</p> <p>In an interview on 10/16/24 at 10:10 a.m., the ADM stated that if a bedside commode/raised toilet chair was noted as rusty or missing paint that it would usually just be tossed in the trash as it couldn't be fixed. He reported that nursing staff would notify maintenance and that the resident would get a new one. He reported potential harm to the resident could occur if the bedside commode/raised toilet chair broke due to rusting or that the resident could be exposed to something if they had a cut on their leg.</p> <p>In an interview on 10/15/24 at 02:00 p.m., a facility maintenance policy was requested. The ADM stated that the facility did not have a policy that covered maintenance and equipment repair, but that if something were broken, the procedure was to put in a maintenance request.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070</p> <p>Based on observation, interviews, and record review the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents for 1 (one medication room for Whispering Way) of four medication rooms reviewed for medication storage.</p> <p>The facility failed to ensure medication supplies were all stored in locked compartments and permit only authorized personnel to have keys when LVN E left the medication room for Hall Whispering Way was left unlocked and unattended by LVN E.</p> <p>This failure could result in resident access and ingestion of medications leading to a risk for harm and possible drug diversion.</p> <p>Findings included:</p> <p>In an observation on 10/13/2024 at 9:19 a.m. revealed an unlocked medication room at the nurse's station on Whispering Way Hallway.</p> <p>In an observation on 10/13/2024 at 10:13 a.m. revealed an unlocked medication room at the nurse's station on Whispering Way Hallway. In the medication room with LVN E revealed stock drugs: Lactose 10mg (for milk intolerance), Sodium Bicarbonate 10.03 gr 650 mg (relieve heartburn and upset stomach), Cranberry tablets (to prevent urinary tract infections), in the refrigerator: Veltassa 16.8 gm oral suspension (to treat high blood potassium), one pneumonia vaccine, Resident #103 (2) packets Veltassa 16.8mg oral Suspension (to treat high blood pressure), Trulicity injections 0.75mg/10, fours syringes (used to treat diabetes), Desmopressin 10mcg/0.1mg two syringes (for diabetes), and a box with four syringes Ozempic 0.25-0.5mg (for diabetes).</p> <p>In an observation and interview on 10/13/2024 at 10:15 a.m. with LVN E revealed the medication room should always remain locked. LVN E stated she forgot to pull the door closed when she left the medication room. LVN E stated the medication room door did not close on it's on. LVN E stated the box of medications on the shelf were for drug destruction, they were picked up by the DON and then placed in a locked storage room on the hallway. The box contained: Resident #120 Metoprolol 25mg (blood pressure medications), Frinsinade 5mg (for enlarge prostate), Resident #121 Clonidine 0.1mg (blood pressure), Resident #122 Atorvastatin 40mg (high cholesterol), Metoprolol 25mg (blood pressures med), [NAME]-sturine 30mg (for blood pressure) and three boxes of Experian solution (wound cleanser). LVN E stated that a resident or a staff member could have access to the medications if the door was not locked and this could cause harm to them if they took the medications.</p> <p>In an interview and observation on 10/14/2024 at 8:20 a.m. with RN F revealed the medications room must stay locked. There were medications in the room that could be stolen or were dangerous for others if the person ingested them. RN F stated that was basic nursing knowledge, you must always keep your medicine room locked, RN F demonstrated with a key you could unlock the medication room door and then it closed automatically and locked.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/15/2024 at 12:45 p.m. with the DON revealed it was her expectation that medication rooms should be always locked. The DON said that the nurses were responsible to keep the medication rooms locked. She stated if they were not locked, residents and unauthorized staff could get into the medication room and there would be opportunities for harm and medication diversion.</p> <p>Review of the Policy and Procedure Medication Access and Storage revised dated July 2023, reflected, It is the policy of the facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications: . Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medications aides) are allowed access to medications. Medications rooms, carts, and medications supplies are locked or attended by persons with authorized access .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47855</p> <p>Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food service safety in the facility's only kitchen, reviewed for food safety.</p> <ol style="list-style-type: none"> 1. The facility failed to correctly label and date a storage bag full of sliced cheese. 2. The facility failed to correctly label a package of diced peppers stored in the refrigerator. 3. The facility failed to label and date 5 supplemental meal bags intended for Dialysis patients. 4. The facility failed to discard the remaining sugar by the written use by date. 5. The facility failed to change the label on a container identified as flour to the actual substance being stored in the container to sugar. <p>These failures could place residents at risk for food-borne illness and cross contamination.</p> <p>Findings included:</p> <p>Observation of the kitchen on 10/13/2024 at 9:40 a.m., revealed in refrigerator 2, a storage bag containing sliced cheese was observed with a date in and no use by date, and no information describing the contents.</p> <p>Observation of refrigerator #1 on 10/13/2024 at 9:43 a.m., revealed 5 storage bags, each containing a bottle of water, a sandwich, and a package of crackers. There were no dates on the bags and no description of the contents. The refrigerator had a note written on the outside that read make 5 Dialysis meals.</p> <p>Observation on 10/13/2024 at 9:45 a.m., of a large white wheeled container sitting on the floor of the kitchen, with label stating Flour was observed with what was later identified as sugar was observed. The container was labeled 09/01/2024 thru 10/01/2024.</p> <p>Observation of refrigerator #3, on 10/13/2024 at 9:46 a.m., a storage bag with cut vegetables was observed stored on the shelf. There was no label indicating what was stored in the bag, when it was placed in the bag and when it should be discarded.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the U.S. FDA Food Code 2022 reflected: Chapter 3 . section 3-201.11 Compliance and Food Law: . C. Packaged Food shall be labeled as specified in Law, including 21 CFR 101 Food Labeling [* .(b) A food which is subject to the requirements of section 403(k) of the act shall bear labeling, even though such food is not in package form. (c) A statement of artificial flavoring, artificial coloring, or chemical preservative shall be placed on the food or on its container or wrapper, or on any two or all three of these, as may be necessary to render such statement likely to be read by the ordinary person under customary conditions of purchase and use of such food. The specific artificial color used in a food shall be identified on the labeling when so required by regulation in part 74 of this chapter to assure safe conditions of use for the color additive.], 9 CFR 317 Labeling, [* (a) When, in an official establishment, any inspected and passed product is placed in any receptacle or covering constituting an immediate container, there shall be affixed to such container a label .Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. Section 3-302.12 Food Storage Containers, Identified with Common Name of Food: Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food. Section 3-501.17 . Commercial processed food: Open and hold cold . B. 1. The day the original container is opened in the food establishment shall be counted as Day 1. 2. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. C. 2. Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section. 3. Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section. Definitions 3. Food Receiving and Storage - When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated.</p>		