

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/22/2026
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident's right to personal privacy during medical treatment for three (Resident #10, #29, and #36) of eight residents reviewed for resident rights. 1. The facility failed to ensure LVN C closed Resident #10's door while checking his blood sugar and administering his insulin on 01/21/2026.2. The facility failed to ensure LVN C closed Resident #36's door before lifting his shirt to turn off his life vest on 01/20/2026.3. The facility failed to ensure RN E pulled the privacy curtain while changing Resident #29's g-tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach) dressing on 01/20/2026. These failures could place the residents at risk of not having their personal privacy maintained while treatment was provided that could result to the residents feeling uncomfortable during treatment. Findings included: 1. Record review of Resident #10's Face Sheet, dated 01/21/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with type 2 diabetes mellitus (high blood sugar). Record review of Resident #10's Quarterly MDS Assessment, dated 01/04/2026, reflected the resident had moderate impairment with a BIMS score of 12. The Quarterly MDS Assessment indicated that the resident had diabetes mellitus and was taking insulin. Record review of Resident #10's Comprehensive Care Plan, dated 01/12/2026, reflected the resident had diabetes mellitus and one of the interventions was to provide diabetes medications as ordered. Record review of Resident #10's Physician Order, dated 12/21/2025, reflected Insulin Regular Human Injection Solution 100 UNIT/ML (Insulin Regular (Human)) Inject as per sliding scale: if 70 - 200 = 0; 201 - 250 = 2; 251 - 300 = 2; 301 - 500 = 3 Greater than 300 administer 3 units, subcutaneously (administer under the skin) before meals and at bedtime for DM II related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS. An observation on 01/21/2025 at 11:33 AM revealed LVN C was about to check Resident #10's blood sugar. She sanitized her hands, put on a pair of gloves, then sanitized the table. She put a paper towel on top of the table where she placed her glucometer, test strips, alcohol wipes, and a push button safety lancet. She went inside the resident's room and positioned herself in front of Resident #10. The resident was in his wheelchair, in front of his door, and could be seen from the hallway and the TV room. It was noted that two individuals were standing in the TV room. LVN C did not close the door while she was checking the resident's blood sugar and the treatment that she was doing could be seen from the hallway. In an interview on 01/21/2026 at 11:49 AM, LVN C stated she forgot to close the door while she was checking Resident #10's blood sugar. She said the door should be closed to provide privacy during treatment or care. She said the resident might get embarrassed that other people could see what his treatments were. In an interview on 01/21/2026 at 11:54 AM, Resident #10 stated that some nurses would close his door when his blood sugar was being checked or if his insulin was given but some would not. He said he got used to the staff not closing his door but it would be nice if his door was closed when given his insulin or if his blood sugar was being checked. 2. Record review of Resident #29's Face Sheet, dated 01/21/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #29's Comprehensive MDS Assessment, dated 12/07/2025, reflected the resident had a severe impairment in cognition with (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675272
		If continuation sheet Page 1 of 28

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 01/22/2026
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had a feeding tube (medical device that helps deliver nutrition and medication directly to the person's stomach). Record review of Resident #29's Comprehensive Care Plan, dated 11/12/2025, reflected the resident required tube feeding and one of the goals was that the feeding tube insertion site would be free from signs and symptoms of infection. Record review of Resident #29's Physician Order, dated 12/04/2025, reflected CLEANSE G-TUBE STOMA WITH NSS, PAT DRY AND APPLY DRY DRESSING. Observation on 01/20/2026 at 1:50 PM revealed RN E was about to change Resident #29's g-tube site. It was observed that the resident was in her wheelchair in front of her bed and her roommate was also inside her room, in her bed. RN E washed her hands and put on a pair of gloves. She removed the soiled dressing, assessed the resident's g-tube site, and put on a new dressing after the assessment. She did not pull the privacy curtain when she did the treatment. In an interview on 01/20/2026 at 2:06 PM, RN E stated she should have pulled the privacy curtain when she was assessing resident #29's g-tube site for privacy reasons. She said the door should be closed every time care and treatment were being provided. 3. Record review of Resident #36's Face Sheet, dated 01/21/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with ventricular fibrillation (abnormal heart rhythm). Record review of Resident #36's Comprehensive MDS Assessment, dated 01/07/2026, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated that the resident had ventricular fibrillation. Record review of Resident #36's Comprehensive Care Plan, dated 01/07/2026, reflected the resident had ventricular fibrillation and one of the interventions was to wear a life vest (wearable defibrillator [devices that apply current to the heart to restore normal heartbeat] that could stop abnormal heart rhythm) daily. An observation on 01/20/2026 at 9:12 AM revealed LVN C was inside Resident #36's room standing at bedside, facing the hallway, and fixing something on the resident's chest. It was observed from the hallway that she lowered the resident's blanket and then raised the resident's upper clothing. It was observed that ADON B went inside the resident's room and closed the door. In an interview on 01/20/2026 at 9:27 AM, LVN C stated she was turning off Resident #36's life vest because the order indicated to turn it off in the morning and that was why she needed to lift the resident's clothes. She said if she was doing a treatment, then she should have closed the door for privacy. In an interview on 01/20/2026 at 1:26 PM, Resident #36 stated he had a life vest and had a battery that was being turned off by a nurse every morning. He said it was under his upper clothing and the nurse needed to raise his shirt or his hospital gown in order to turn it on and off. He said he did not notice if the staff closed the door or not and but it won't hurt if the door would be closed. In an interview on 01/22/2026 at 8:23 AM, the DON stated that the door should be closed every time the staff provided care or treatment to give privacy and prevent improper exposure of any body part. She said turning off the life vest, checking the blood sugar, and assessing the g-tube site were treatments done for the resident so their doors should be closed so others, like non-clinical personnel, visitors, and other residents would not see the treatments being done. She said the door should be closed or the privacy curtain pulled to avoid embarrassment. She said, aside from being embarrassed, closing the door and pulling the privacy curtain could make the residents more comfortable during treatment. She said the expectation was for the staff to provide privacy during treatment. She said she already started an in-service about providing privacy during treatment. In an interview on 01/22/2026 at 8:43 AM, ADON A stated the staff should close the door or pull the privacy curtain when they were providing care to the residents. He said the staff needed to get used to providing privacy during treatment so that individuals that did not have anything to do with the residents' care would not see it. He said it did not matter if the residents mind or not, but the expectation was for the staff should be sensible enough that if they were in the residents' position, they might want their door closed during treatment. He said the DON already started an in-service about closing the door during treatment. In an interview on 01/22/2026 at 8:57 AM, ADON B stated that the staff should close the door when they were doing any kind of treatment to the residents for privacy. She said the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/22/2026
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expectation was for the staff to provide privacy by closing the residents' door or pulling the privacy curtain. She said the DON already started an in-service about privacy. In an interview on 01/22/2026 at 9:27 AM, the Administrator stated that the staff must make sure that the residents were provided privacy when treatment was being done so they would be comfortable when treatment was provided. He said the expectation was for the staff to be mindful about privacy when providing treatment. He said he would collaborate with the DON and the ADONs to re-educate the staff about the importance of providing privacy. Record review of the facility's policy, Resident Rights Services revised October 04, 2016, reflected As a resident of this nursing facility, you have the right to a dignified existence . Privacy and Confidentiality. You have the right to personal privacy . personal privacy, including accommodations, medical treatment.		

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 01/22/2026
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the right to a safe, clean, comfortable, and homelike environment including housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 10 of 20 resident rooms (room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, #9, and #10) observed for cleanliness. The facility failed to ensure Resident Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10 were thoroughly cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: An observation on 01/20/26 at 10:57 AM of room [ROOM NUMBER], reflected the windowsill had dirt and dead gnats. The shower floor had a rust like substance near a shower wall, and black and white substances around the center of the shower floor. The bathroom floor had white substances under the sink and near the toilet. had grayish dirt stains on the floor under the sink and grayish and brownish stains around the toilet area. The paper towel dispenser had dust and white substances all over the outer shell. An observation on 01/20/26 at 11:10 AM of room [ROOM NUMBER], reflected the windowsill had dirt and dead gnats. The air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The shower floor had black substances near the shower walls and around the center of the shower floor. The bathroom floor had white substances under the sink and around the toilet. An observation on 01/20/26 at 11:15 AM of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. An observation on 01/20/26 at 11:18 AM of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The shower floor had black and substances near the shower walls and around the center of the shower floor. The bathroom floor had white substances under the sink and around the toilet. An observation on 01/20/26 at 11:21 AM of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The windowsill had a reddish spill stain on the windowsill and going down the wall under the windowsill. An observation on 01/20/26 at 11:24 AM of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The bathroom floor had white substances under the sink and around the toilet. The shower floor had black and substances near the shower walls and around the center of the shower floor. An observation on 01/20/26 at 11:30 AM of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. An observation on 01/20/26 at 11:33 AM, of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The bathroom floor had white substances under the sink and around the toilet. An observation on 01/20/26 at 11:35 AM of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The windowsill had black stains along the windowsill. The bathroom floor had black stains under the sink and around the toilet. The shower floor had black and substances near the shower walls and around the center of the shower floor. An observation on 01/20/26 at 11:43 AM of room [ROOM NUMBER], reflected the air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The bathroom floor had white substances under the sink and around the toilet. The shower floor had black and substances near the shower walls and around the center of the shower floor. In an interview on 01/22/26 at 10:05 AM, Housekeeping S stated she had been at the facility for nearly 19 years. She stated she cleaned the rooms on the Veteran's Way Hall. She stated they were to clean the entire room, which included the bathrooms, Air conditioning units, the mini fridges, and floors. She was shown pictures of the concerns observed in Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10, She stated if the rooms were (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/22/2026
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not thoroughly cleaned it could cause respiratory problems. In an interview on 01/22/26 at 10:05 AM, the Housekeeping Supervisor stated he had been at the facility for 8 years. He stated he trained housekeeping to clean from the back of the room to the front. He stated they mop, dust, clean bathrooms. He was shown pictures of the concerns observed in Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10, and he stated it could impact the reputation of the facility. He stated the areas of concern would be addressed today. In an interview on 01/22/26 at 11:30 AM, The Administrator was told about the concerns observed in Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10. He stated they had plenty of staff in housekeeping and he expected the rooms to be thoroughly cleaned. He stated he would follow up with the Housekeeping Supervisor to ensure corrections were made. Review of the facility's policy on Safe/Comfortable/Homelike Environment (01/2022) revealed Resident are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics includes cleanliness and order.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/22/2026
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 4 of 8 residents (Resident #28, # 87, #136, and #147) reviewed for ADL care provided to dependent residents. The facility failed to ensure Residents #28, #87, #136, and #147 received their scheduled showers for January 2026. This failure could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self- esteem. Findings included: Record review of Resident #28's Face Sheet, dated 01/21/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #28 had diagnoses of muscle weakness and need for assistance with personal care. Record review of Resident #28's Quarterly MDS Assessment, dated 12/26/25, reflected the resident had moderate cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnoses of muscle weakness and need for assistance with personal care. The resident required total assistance for ADL care. Record review of Resident #28's Comprehensive Care Plan, dated 12/23/25, reflected the resident had an ADL self-care deficit and the resident was totally dependent on staff to provide ADL care. Record review of the shower sheets for Resident #28 for January 2026, revealed no showers being provided to the resident until 01/21/26. In an interview and observation on 01/20/26 at 12:00 PM, Resident #28 stated he had only received maybe two bed baths since he had been at the facility. He stated he wanted his scheduled showers but was only given excuses by the nursing staff why he could not get a shower. The Resident's hair was matted in the back. Record review of Resident #87's Face Sheet, dated 01/21/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #87 had diagnoses of muscle weakness and need for assistance with personal care. Record review of Resident #87's Quarterly MDS Assessment, dated 12/13/25, reflected the resident had moderate cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnoses of muscle weakness and need for assistance with personal care. The resident required substantial assistance for ADL care. Record review of Resident #87's Comprehensive Care Plan, dated 12/11/25, reflected the resident had an ADL self-care deficit and the resident required assistance with bathing/showering. Record review of the shower sheets for Resident #87 for January 2026, revealed one shower was provided to the resident on 01/05/26. In an interview on 01/20/26 at 10:52 AM, Resident #87 stated he had only received one shower so far in January 2026. He stated he was scheduled for showers on Tuesday, Thursday, and Saturday. He stated he liked receiving his showers and had only refused one shower because he was too tired from doing physical therapy, but they had not rescheduled it. Record review of Resident #136's Face Sheet, dated 01/21/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #136 had diagnoses of muscle weakness and lack of coordination. Record review of Resident #136's Quarterly MDS assessment, dated 12/31/25, reflected the resident had an intact cognitive response. The Quarterly MDS Assessment reflected the resident had active diagnoses of muscle weakness and lack of coordination. The resident required substantial assistance for ADL care. Record review of Resident #136's Comprehensive Care Plan, dated 10/22/25, reflected the resident had an ADL self-care deficit and the resident required assistance with bathing/showering. Record review of the shower sheets for Resident #136 for November 2025, December 2025, and January 2026, revealed no showers being provided to the resident, but instead bed baths. In an interview and observation on 01/20/26 at 11:07 AM, Resident #136 stated he had been at the facility for nearly a year and had only received bed baths. He stated he really wanted showers but was told by CNAs they did not have a shower chair large enough to hold him. He stated the bed baths cannot clean him as thoroughly as showers could. The resident was observed with a black substance under his fingernails. Record review of Resident #147's Face Sheet, dated 01/21/26, reflected a [AGE] (continued on next page)		

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 01/22/2026
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	year-old male who was admitted to the facility on [DATE]. Resident #147 had diagnoses of muscle weakness and lack of coordination. Record review of Resident #147's Initial MDS assessment, dated 01/11/26, reflected the resident had an intact cognitive response. The MDS revealed the resident required substantial assistance for ADL care. Record review of Resident #147's Comprehensive Care Plan, dated 01/10/26, reflected the resident had an ADL self-care deficit and the resident required assistance with bathing/showering. Record review of the shower sheets for Resident #147 for January 2026, revealed one shower provided to the resident on 01/14/26. In an interview on 01/20/26 at 12:33 PM, Resident #147 stated he had been at the facility for 10 days and had only received one shower since being there. He stated he was scheduled for 3 showers a week and staff had made excuses why he could not receive them. He stated he wanted his showers. In an interview on 01/20/26 at 1:20 PM, ADON B, LVN I, and CNA A were told about Residents #28, #87, #136, and #147 complaining about not receiving their showers on a consistent basis. ADON B stated she had been trying to reinforce to staff the importance of ensuring showers were being documented on shower sheets. CNA A stated he had provided a shower to Resident#87 on 01/12/26, but he did not complete a shower sheet for the resident. ADON B stated protocol was for CNAs to complete shower sheets for the residents and then update the resident's clinical records. CNA A stated if residents did not get their scheduled showers they could have skin problems. LVN I stated if residents did not receive their scheduled showers they could have skin breakdown. In an interview on 01/21/26 at 9:50 AM, ADON B was informed by the Surveyor of Resident #28 and #136 complaining of not receiving showers. She stated Resident #28 was aggressive with staff and often refused showers and only did bed baths. She was informed the resident stated he wanted showers and his hair was also observed to be matted. She was also informed there was no documentation in the resident's progress notes indicating he was refusing showers nor was there a care plan for his refusal of showers. ADON B was informed Resident #136 stated he wanted showers but CNAs kept telling him there was no shower chair large enough for him. She stated Resident #136 was also cared planned for refusing showers. She was informed that Resident #136's progress notes were reviewed going back to November 2025 and there was no documentation of an attempt to provide the resident with a shower, nor was there any documentation of the resident refusing a showers. She stated staff, including herself, should have documented attempts made to offer showers to the resident and his refusals. She stated the residents not receiving their showers could result in skin breakdown. In an interview on 01/22/26 at 8:51 AM, the DON was informed of Residents #28, #87, #136, and #147 complaining about not receiving their showers and she stated ADON B had advised her of the residents not having shower sheets indicating the residents received showers. She stated if the resident refused a shower, a bed bath should be offered. She stated if the resident wants a bed bath instead of a shower the CNA should inform the nurse, and the nurse should confirm the resident agreed to the bed bath and it should be documented. She stated if the resident refused a shower and bed bath, the nurse should attempt to persuade the resident to take a shower or bed bath and contact a family member to encourage them as well. She stated if the residents did not receive scheduled showers they could have skin breakdown. Record review of the facility's policy on Activities of Daily Living (ADL), Supporting, dated December 2001, revealed, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, including assistance with hygiene (bathing, dressing, grooming, and oral care).		

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 01/22/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of hazards as was possible for five of eighteen residents (Residents #22, #27, #49, #105, and #122) and three of six direct staff (ADON A, MA G, and LVN H) reviewed for accident hazard.1. The facility failed to ensure Resident #22 did not have 2 cans of aerosol air freshener spray in his room on 01/20/2026. 2. The facility failed to ensure Resident #27 did not have a can of Lysol spray in his room on 01/20/2026. 3. The facility failed to ensure Resident #49 did not have a pump bottle of hand sanitizer, a can of Lysol spray, and sanitizing wipes in his room on 01/20/2026.4. The facility failed to ensure Resident #105 did not have a can of aerosol air freshener spray in his room on 01/20/2026.5. The facility failed to ensure Residents #122's bed was lowered to the lowest position possible while she was lying in the bed.6. The facility failed to ensure ADON A did not leave a container of germicidal (substance that destroys germs and microorganism) wipes on top of his cart on 01/20/2026.7. The facility failed to ensure MA G did not leave a container of germicidal wipes on top of her cart on 01/20/2026.8. The facility failed to ensure LVN H did not leave a container of germicidal wipes on top of his cart on 01/21/2026. These failures could prevent the residents from having an environment that was free from toxic chemicals. Findings include:1. Resident #22Record review of Resident #22's face sheet, dated 01/22/2026, reflected a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included malignant neoplasm of urinary organ (bladder cancer), heart failure (heart muscle doesn't pump blood as well as it should), and chronic kidney disease (progressive damage and loss of kidney function). Record review of Resident #22's MDS Nursing Home and Swing Bed Tracking, dated 12/29/2025, did not include Section C (Cognitive Patterns). The MDS Assessment indicated Resident #22 admitted to the nursing facility from a hospital. It did not reflect the resident's acts of daily living. Record review of Resident #22's Comprehensive Care Plan, dated 12/19/2026, reflected he was at risk for impaired cognitive function or impaired thought process related to cognitive communication deficit. One intervention was Needs supervision/assistance with all decision making. During an observation on 01/20/2026 at 9:07 AM, Resident #22 was observed lying in bed asleep. A can of air freshener spray was on his nightstand. There was also a can of air freshener spray on a counter at the entrance of his room. 2. Resident #27Record review of Resident #27's face sheet, dated 01/22/2026, reflected a [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with neurocognitive disorder with Lewy bodies (progressive decline in mental function that affects thinking, behavior, movement, and sleep). Record review of Resident #27's MDS Interim Payment Assessment, dated 01/11/2026, indicated a BIMS Assessment was appropriate but was not conducted. The staff assessment for mental status was not completed. Section GG (Functional Abilities) indicated Resident #27 required assistance with mobility and self-care needs. Record review of Resident #27's Comprehensive Care Plan, dated 01/16/2026, reflected the resident was at risk for impaired cognitive function or impaired thought processes related to a diagnosis of dementia. Interventions included to Engage in simple, structured activities that avoid overly demanding tasks and Give step by step instruction on at a time as needed to support cognitive function. During an observation and interview on 01/20/2026 at 10:09 AM, Resident #27 was lying in bed asleep. A family member was sitting at the table in his room. There were personal items on the table. There was also a bottle of Lysol spray and a bottle of multi-surface cleaner on the table. The family member stated the resident was unable to get up and get the cleaning products. The family member stated she ate and spent time on projects at the table and liked to clean up after herself.3. Resident #49Record review of Resident #49's face sheet, dated 01/22/2026, reflected a [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with cognitive communication deficit (difficulty communicating because of impaired cognitive function). (continued on next page)		

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 01/22/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #49's Quarterly MDS Assessment, dated 01/05/2026, indicated severe cognitive impairment with a BIMS score of 04. Section GG (Functional Abilities) indicated Resident #49 required assistance with mobility and self-care needs. Record review of Resident #49's Comprehensive Care Plan, dated 01/19/2026, reflected he was at risk for impaired cognitive function or impaired thought process related to cognitive communication deficit. One intervention was to Keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. An observation on 01/20/2026 at 9:10 AM revealed Resident #49 was not in his room. There was a 32 ounce pump bottle of alcohol hand sanitizer on his nightstand. There was a can of Lysol spray, a container of germicidal wipes, and a container of Lysol sanitizing wipes on the counter at the entrance of his room. During an observation an interview on 01/20/2026 at 9:27 AM, Resident #49 was sitting near the nurse's station in his wheelchair. An interview was attempted but Resident #49 did not answer questions appropriately related to his cognitive status. LVN I was standing near the nurse's station and stated Resident #49 was a fall risk and near the nurses' station so staff could monitor him. 4. Resident #105 Record review of Resident #105's face sheet, dated 01/22/2026, reflected a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. He had diagnoses which included dementia (loss of thinking, remembering, and reasoning skills) and cognitive communication deficit. Record review of Resident #105's Quarterly MDS Assessment, dated 12/31/2025, indicated a BIMS assessment was appropriate for the resident but was not conducted. The staff assessment for mental status was not completed. Section GG (Functional Abilities) indicated Resident #105 required set-up with some, but was independent with most self-care needs. Record review of Resident #105's Comprehensive Care Plan, dated 01/20/2026, reflected alteration in neurological status related to disease process including dementia and history of cerebral ischemia (brain does not receive enough blood flow). An intervention was to cue resident and reorient as needed. During an observation and interview on 01/20/2026 at 9:51 AM, Resident #105 was sitting on the side of his bed. There was a can of air freshener spray on the counter near his door. Resident #105 stated he did not know how long it had been on the counter or when it was used. During an interview on 01/20/2026 at 10:12 AM, LVN I stated family members may have left the air freshener sprays and cleaning products in the residents' rooms. LVN I stated they should not have been out where any resident could get to them. She stated some residents were confused and it was not safe to have the items in reach. She stated they would check the rooms on her hall to ensure they were removed. During an interview on 01/20/2026 at 10:15 AM, ADON B stated there should not have been aerosol sprays, cleaning products, or peroxide in the residents' rooms. She stated some residents use oxygen or have asthma or COPD. She stated the aerosol sprays could exacerbate (make worse) respiratory illnesses. She stated a resident who wandered or was confused could ingest the products or try to use them for other reasons. 5. Resident #122 Record review of Resident #122's Face Sheet, dated 01/21/26, reflected she was an [AGE] year-old female admitted to the facility on [DATE] and relevant diagnoses included muscle weakness and history of falls. Record review of Resident #122's Quarterly MDS assessment, dated 10/11/25, reflected the resident had a severe cognitive impairment. For ADL care, it reflected the resident required extensive assistance and an active diagnosis of muscle weakness and history of falls. Record review of Resident #122's Comprehensive Care Plan, dated 10/30/25, reflected the resident was a fall risk, and an intervention included the resident's bed being in the lowest position possible. In an interview and observation on 01/20/26 at 01:16 PM, LVN O stated Resident #122 was a fall risk and her bed should be in a low position to reduce the height of the fall and prevent injuries. LVN O observed the bed not in a low position and she proceeded to lower the bed. In an interview on 01/22/26 at 8:51 AM, the DON was advised of Resident #122's bed not being in a low position. She stated the resident's bed should be in a lot position because if she fell the impact would not be as bad. She stated the nurses should be checking to ensure the resident's bed was in the lowest position and the CNAs should ensure the resident's bed was lowered to the lowest position after providing care. 6. An observation on 01/20/2026 at 9:47 AM (continued on next page)		

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 01/22/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed ADON A was called to check on a resident's call light. He locked his cart and went to the resident's room. A container of germicidal wipes was on top of his cart that was facing the hallway. it was observed that several residents were passing by the cart. In an interview on 01/22/2026 at 8:43 AM, ADON A stated there should be no germicidal wipes on top of the carts because residents might pull some wipes and rub them on their skin and eyes that might cause irritations. He said the container of germicidal wipes should be locked inside the carts. An observation on 01/20/2026 at 2:25 PM revealed a container of germicidal wipes was on top of a cart in a hallway near the nurses' station. The cart parked was facing the hallway and several residents were sitting near the cart. In an interview on 01/20/2026 at 2:27 PM, MA G stated they would always put the container of germicidal wipes on top of the cart because they use it to clean the cart. She said the wipes only contain alcohol and did not think they should be stored inside the cart. In an interview on 01/21/2026 at 8:19 AM, MA G stated she just learned from the day prior that they need to store the containers of germicidal wipes inside the carts for safety reasons. She said confused residents might consume them and could cause an upset stomach. 8. An observation on 01/21/2026 at 10:47 AM revealed a container of germicidal wipes was on top of a cart that was facing the hallway and was unattended. During an observation and interview on 01/21/2026 at 10:49 AM, ADON B stated the germicidal wipes should be stored inside the cart for safety reasons. She said residents might think they were ordinary wipes and use them to clean their eyes, nose, ears, and skin. She said it might cause irritation and toxicity. She said anything that indicated Keep out of reach of children. should be considered harmful because the facility had confused residents that may not know the outcome if the germicidal wipes were used. She took the container of germicidal wipes and put it inside the nurse's station. In an interview on 01/21/2026 at 10:56 AM, LVN H stated that that he should have secured the germicidal wipes before leaving the cart because residents might use it improperly or even eat it. He said the container of germicidal wipes should be locked inside the cart. During an interview on 01/21/2026 at 10:30 AM, the DON stated the aerosol sprays and cleaning products should not have been in the residents' rooms. She stated aerosol sprays were not allowed because they were combustible and oxygen was used in the building. She stated germicidal wipes should be stored in a nurse's cart. She stated one resident's family came on weekends and cleaned his room while at the facility. She stated they would notify all residents' families not to bring aerosols or cleaning products to the facility. She stated her expectation was for staff to monitor residents' rooms to ensure those types of items were not left in any resident's room. In an interview on 01/22/2026 at 8:23 AM, the DON stated that the containers of germicidal wipes should not be placed or left on top of the cart because they have chemicals that could cause adverse effects if consumed or had contact with the skin, eyes, and mouth. She said the container of germicidal wipes was closed but somebody could open it pull some wipes with their bare hand. She said the wipes were handled with gloves on because they have chemical on them to eliminate germs on surfaces. She said the containers should be inside the carts. She said she already started an in-service about not leaving any germicidal wipes on top of the carts for resident safety. In an interview on 01/22/2026 at 9:27 AM, the Administrator stated that the containers of germicidal wipes should be inside the carts and not within reach of any residents. He said some residents might accidentally use them that could result to skin or eye irritation. He said he would collaborate with the DON and the ADONS to re-educate the staff about not placing or leaving the germicidal wipes on top of the carts. Record review of the facility's policy Safety, Resident Policy/Procedure revised July 2023 reflected POLICY: It is the policy of this facility to create a safe environment for the resident . PROCEDURES . 7. Conduct a room search should there be concern that prohibited/unsafe items are being stored in the room. Record review of Safety Data Sheet on 01/21/2026 reflected Safety Data Sheet Medline Micro-Kill Two Germicidal Wipes . Section 2. Hazards Identification . Classification . acute toxicity - oral . eye irritant . flammable liquids . Hazard Statements: Causes serious eye irritation . Flammable liquid and vapor . May cause drowsiness or dizziness . Storage: Keep out of the reach of children. The facility's policy Quality of Care (12/2023) reflected It is the policy of the facility (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/22/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to provide an environment that remain free of accidents and hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.		

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 01/22/2026
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for five of sixteen residents (Residents #12, #87, #32, #91, and #102) reviewed for respiratory care.1. The facility failed to ensure Resident #12's BiPAP mask was stored in a bag when not in use on 01/20/2026.2. The facility failed to ensure Resident #87's breathing mask was stored in a bag when not in use on 01/20/2026. 3. The facility failed to ensure Resident #32's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was stored properly when not in use on 01/20/2026. 4. The facility failed to ensure Resident #91's breathing mask (a medical device used to deliver medication in the form of mist directly to the lungs) was stored properly when not in use on 01/20/2026.5. The facility failed to ensure Resident #102's nasal canula was properly stored in a bag when not in use on 01/20/2026. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings include: Resident #12 Record review of Resident #12's face sheet, dated 01/22/2026, reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. He had a diagnosis of acute respiratory failure with hypoxia (sudden decrease of oxygen levels in the blood). Record review of Resident #12's Quarterly MDS (tool used to measure health status) Assessment, dated 12/29/2025, reflected intact cognition with a BIMS (tool used to measure cognitive status) score of 11. Section O (Special Treatments, Procedures, and Programs) indicated his respiratory treatments included non-invasive mechanical ventilation (delivers airway pressure to assist breathing through a mask). Record review of Resident #12's Comprehensive Care Plan, dated 12/10/2025, did not reflect the BiPAP machine. Record review of Resident #12's Physician's Orders, dated 11/24/2025, reflected to use the BiPAP at bedtime related to acute respiratory failure with hypoxia. An observation and interview on 01/20/2026 at 9:14 AM revealed Resident #12 lying in bed awake. A BiPAP with an attached nasal mask (covers only your nose and delivers pressurized air directly through the nasal passage) not stored in a bag and laid on the resident's nightstand. Resident #12 stated he wore the BiPAP nasal mask at bedtime. Resident #87 Record review of Resident #87's face sheet, dated 01/22/2026, reflected a [AGE] year-old male who admitted to the facility on [DATE]. He had a diagnosis of iron deficiency anemia (the body lacks enough iron to produce healthy blood cells, which carries oxygen throughout the body). Record review of Resident #87's Quarterly MDS (tool used to measure health status) Assessment, dated 12/13/2025, reflected moderately impaired cognition with a BIMS (tool used to measure cognitive status) score of 11. Section O (Special Treatments, Procedures, and Programs) indicated Resident #87 received respiratory treatments. Record review of Resident #87's Comprehensive Care Plan, dated 12/10/2025, did not reflect breathing treatments. Record review of Resident #87's Physician's Orders, dated 12/10/2025, reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 3 ml inhale orally every 6 hours as needed for SOB administer 3ml via nebulizer. An observation on 01/20/2026 at 9:02 AM revealed Resident #87 lying in bed asleep. A nebulizer was on the nightstand. The face mask and tubing was connected to the nebulizer. It was not stored in a bag. During an interview on 01/20/2026 at 10:12 AM, LVN I stated Resident #87's breathing mask should have been stored in a bag. She stated Resident #12's BiPAP mask should have also been in a bag. LVN I stated she had not noticed the items were not bagged. She stated it was important to prevent contamination and infection. Resident #32 Record review of Resident #32's Face Sheet, dated 01/21/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #32's Quarterly MDS Assessment, dated 10/22/2025, reflected the resident had a moderate (continued on next page)		

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 01/22/2026
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment indicated the resident had chronic obstructive pulmonary disease and was on oxygen therapy. Record review of Resident #32's Comprehensive Care Plan, dated 12/10/2025, reflected the resident was at risk for increased SOB and one of the interventions was give oxygen therapy as ordered. Record review of Resident #32's Physician's Order, dated 11/19/2025, reflected O2 AT 3 L/MIN CONTINUOUS PER Nasal cannula every shift related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA (insufficient amount of oxygen in the body); MORBID (SEVERE) OBESITY WITH ALVEOLAR HYPOVENTILATION (breathing that is too shallow or too slow to meet the needs of the body); CHRONIC OBSTRUCTIVE PULMONARY DISEASE. Observation on 01/20/2026 at 9:55 AM revealed Resident # 32 was in her bed with eyes closed. It was observed that a nasal cannula was attached to an oxygen tank at the back of the resident's wheelchair. The nasal cannula was not bagged and was on the floor. It was also observed that there was no bag at the back of the wheelchair. During an observation and interview on 01/20/2026 at 9:57 AM, RN E stated the nasal cannula was supposed to be bagged when Resident #32 was not using it to prevent respiratory infection. She said she did not notice that the resident's nasal cannula was on the floor when she checked the resident. She said she did not know who was the last one who transferred the resident and did not know how long it had been on the floor. She disconnected the nasal cannula, threw it in the trash can, and said she would get a new nasal cannula and a bag. Resident #91 Record review of Resident #91's Face Sheet, dated 08/13/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with fatigue (persistent state of physical or mental exhaustion) and anemia (a problem of not having enough healthy red blood cells to carry oxygen to the body's tissue). Record review of Resident #91's Quarterly MDS Assessment, dated 11/27/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 03. The Quarterly MDS Assessment indicated the resident had fatigue and anemia. Record review of Resident #91's Comprehensive Care Plan, dated 07/29/2025, reflected the resident had hypoxia and one of the interventions was give aerosol (substance released in fine mist) or bronchodilators (medication that caused widening of the air passages) as ordered. Record review of Resident #91's Physician's Order, dated 12/16/2025, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally four times a day for Wheezing for 14 Days. During an observation and interview on 01/20/2026 at 9:20 AM revealed Resident #91 was in his bed, awake. It was observed that a nebulization machine was on top of the resident's side table with a breathing mask connected to it. The breathing mask was inside the drawer and was not bagged. There was no bag inside the drawer. The resident said he was not using it anymore and he did not know why it was still inside his room. He said he could not remember if the staff were bagging it or not. Observation and interview with LVN C on 01/21/2026 at 8:13 AM, LVN C stated Resident #91's order for the breathing treatment was already done. She said the resident only had it for fourteen days. She said if it was already done, the breathing mask should have been disconnected but if it was still inside the resident's room then it should be bagged in case it would be used again. She went inside the resident's room, disconnected the breathing mask, and threw it in the trash can. She said there might be an emergency that a breathing treatment was needed and the resident would be using a dirty breathing mask that could eventually cause respiratory infection. Resident #102 Record review of Resident #102's Face Sheet, dated 01/21/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #102 had acute respiratory failure with hypoxia (low oxygen intake) and a need for assistance with personal care. Record review of Resident #102's Quarterly MDS Assessment, dated 11/08/25, reflected Resident #102 had an intact cognitive response. The Quarterly MDS Assessment reflected the resident had active diagnoses of respiratory failure and congestive heart failure. Record review of Resident #102's Physician Orders dated 01/21/26, reflected O2 at 3 L/MIN Continuous via nasal cannula. In an observation and interview on 01/20/26 at 11:55 AM, LVN T stated Resident #102 went out on a smoke break at 11:30 AM. She observed the nasal canula sitting on top of the bed unbagged and she stated it should be bagged because it could cause an (continued on next page)		

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 01/22/2026
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection.During an interview on 01/20/2026 at 10:15 AM, ADON B stated the nebulizer mask and BiPAP mask should have been stored in a bag. She stated nursing staff were responsible for ensuring they were bagged and kept clean for infection control. During an interview on 01/21/2026 at 10:30 AM, the DON stated the nebulizer mask and BiPAP mask should have been stored in a bag. She stated residents inhale when putting the masks on. She stated the nursing staff were responsible for ensuring the items were bagged to prevent contamination and for infection control. In an interview on 01/22/2026 at 8:23 AM, the DON stated the nasal cannula and the breathing masks should be bagged whenever the residents were not using them. She said whoever transferred the resident should have placed the nasal cannula inside a bag and if there was no bag, then they should look for one or ask for one. If the resident was not using the nebulizer anymore, then the breathing mask should have been thrown away, if it was still inside the room then it should still be bagged. She said she already initiated and in-service about bagging the nasal cannula and the breathing masks. She said, moving forward, she would randomly monitor the staff if they were bagging them when not in use.In an interview on 01/22/2026 at 8:57 AM, ADON B stated breathing masks and nasal cannula should be stored properly to prevent cross contamination and respiratory infections. She said whoever administered the breathing treatment was responsible for cleaning it and storing it in a plastic bag. She said whoever transferred any resident with a nasal cannula should put it inside a plastic bag, so it would be clean for the next use. She said the expectation was for the staff to bag the nasal cannula and the breathing mask when not in use. She said the DON already started an in-service about respiratory care.In an interview on 01/22/2026 at 9:27 AM, the Administrator stated the expectation was for the staff to bag the nasal cannula and the breathing mask when not in use to prevent respiratory issues. He said he would collaborate with the DON and the ADONs to re-educate the staff about bagging the nasal cannula and the breathing masks. Record review of the facility's policy Oxygen Equipment Policy/Procedure - Nursing Clinical revised May 2007 reflected POLICY: It is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner . PROCEDURES . 1. Oxygen Tanks, Connectors and Concentrators . E. When mask or cannula is temporarily not being used, it will be covered loosely to prevent contamination from airborne microorganisms . 2. Nebulizer Equipment Procedures . F. Store, clean, and dry until next use.		

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 01/22/2026
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under property temperature controls, and permitted only authorized personnel to have access to the keys for four of eighteen residents (Residents #35, #105, #102, and #150) reviewed for medication storage.1. The facility failed to ensure LVN H did not leave Resident #35's medication on top of the medication aide's cart unattended on 01/21/2026. 2. The facility failed to ensure a bottle of over-the-counter peroxide was not in Resident #105's room on 01/20/2026.3. The facility failed to ensure that a nasal spray was not inside Resident #102's room on 01/20/2026.4. The facility failed to ensure an antifungal and topical (delivering medications directly to the skin) roll-on analgesic were not inside Resident #150's room on 01/20/2026. These failures could place the residents at risk of accidental overdose, misuse of medications, and possible adverse reactions. Findings include: Resident #35 Record review of Resident #35's Face Sheet, dated 01/21/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure). Record review of Resident #35's Comprehensive MDS Assessment, dated 11/28/2025, reflected the resident was cognitively (resident capable of normal cognition and needs little support) intact with a BIMS 14. The Comprehensive MDS Assessment indicated the resident had hypertension. Record review of Resident #35's Comprehensive Care Plan, dated 12/10/2025, reflected that the resident had hypertension and one of the interventions was to give medications as ordered. Record review of Resident #35's Physician's Order, dated 01/05/2026, reflected (Propranolol HCl) Give 1 tablet by mouth two times a day for HTN related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold for SBP less than 110 DBP less than 60 HR less than 60. An observation on 01/21/2026 at 7:49 AM revealed that LVN H was preparing Resident #35's medication. While preparing the resident's anti-hypertensive medication, he dropped two pills of the said medication. He picked up the excess pill, put it in a small cup, and placed it on top of the cart. He continued to prepare the resident's medications and then went inside the resident's room to administer them. He left the cup with medication on top of the cart unattended when he went inside the resident's room. The cart was facing the hallway and was parked across from the resident's room. During an observation and interview on 01/21/2026 at 7:51 AM, LVN H stated he should not have left Resident #35's medication on top of the cart unattended. He said he should have disposed of it before leaving his cart because a resident might pick it up and take it. He said the resident who took it might be taking the medications crushed and might choke on it. He took the medication and disposed of it. In an interview on 01/22/2026 at 8:23 AM, the DON stated the excess pill should have been disposed immediately because a resident might get hold of it, consume it and choke on it or was allergic to it. She said the expectation was that no medication would be left on top of the cart unattended. She said she already started an in-service about medication administration. In an interview on 01/22/2026 at 8:57 AM, ADON B stated that staff should not leave any medications unattended because a resident might get hold of it, drink it, and choke from it or be allergic to it. She said the DON already started an in-service about not leaving the medications unattended on top of the carts. In an interview on 01/22/2026 at 9:27 AM, the Administrator stated that the expectation was for the staff would not leave medications on top of the cart unattended because of the risk for any resident to take something that was not needed. He said he would collaborate with the DON and the ADONs to re-educate the staff about not leaving any medications on top of the cart unattended. Resident #105 Record review of Resident #105's face sheet, dated 01/22/2026, reflected a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. He had diagnoses which included dementia (loss of thinking, remembering, and reasoning (continued on next page)		

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 01/22/2026
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	skills) and cognitive communication deficit. Record review of Resident #105's Quarterly MDS Assessment, dated 12/31/2025, indicated the resident did not have a BIMS assessment conducted. The staff assessment for mental status was not completed. Record review of Resident #105's Comprehensive Care Plan, dated 01/20/2026, reflected alteration in neurological status related to disease process including dementia and history of cerebral ischemia (brain does not receive enough blood flow). An intervention was to cue resident and reorient as needed. Record Review of Resident #105's Physician's Orders revealed there was no order to use peroxide. During an observation and interview on 1/20/26 at 9:51 AM, Resident #105 was sitting on the side of his bed. There was a bottle of peroxide on the counter near the door of his room. Resident #105 stated he did not know how long it had been there or when it was used. During an interview on 01/20/2026 at 10:12 AM, LVN I stated the peroxide should not have been in Resident #105's room. She stated she had not noticed it on the counter in his room. She stated some residents were confused and it should not be out where a resident could get it. LVN I stated they would remove it from the resident's room. During an interview on 01/20/2026 at 10:15 AM, ADON B stated the bottle of peroxide should not have been in Resident #105's room. She stated a resident who wandered or was confused might ingest it or try to use it for other reasons. During an interview on 01/21/2026 at 10:30 AM, the DON stated the peroxide should not have been in Resident #105's room. She stated her expectation was for staff to monitor to ensure potentially harmful items were not left in residents' rooms. Resident #102 Record review of Resident #102's Face Sheet, dated 01/21/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease and dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #102's Quarterly MDS Assessment, dated 12/02/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 10. The Quarterly MDS Assessment indicated the resident had chronic obstructive pulmonary disease and dementia. Record review of Resident #102's Comprehensive Care Plan, dated 12/16/2025, reflected the resident had chronic obstructive pulmonary disease monitor difficulty in breathing. Record review of Resident #102's Physician Order, dated 02/16/2024, reflected Saline Nasal Spray Solution (Saline) 1 spray in each nostril every 2 hours as needed for Congestion. Observation and interview on 01/20/2026 at 9:44 AM revealed Resident #102 was in his bed, awake. It was observed that a nasal spray was on top of the resident's side table and was on plain view. The resident said it had always been in his side table and he did not know if somebody noticed it. Observation and interview on 01/20/2026 at 9:49 AM, ADON A stated he did not notice the nasal spray inside Resident #102's room when he did his morning round. He said the nasal spray should be inside the cart and the staff should be the one administering it. He said he was not sure if the resident was using it, but if he did, the resident might use it more than the recommended dose and could result to irritation. He also said that confused resident might also get hold of the nasal spray. He said sometimes family members would bring the medication and would not let the staff know. He said they would also educate the family members about the potential harm of medications inside the rooms of the residents. ADON A went inside the resident's room and took the resident's nasal spray. Resident #150 Record review of Resident #150's Face Sheet, dated 01/21/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia and osteoarthritis (a type of arthritis that happens when the cartilage that lines your joints is worn down and your bones rub against each other). Record review of Resident #150's Comprehensive MDS Assessment, dated 01/10/2026, reflected the resident had a moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment indicated the resident had dementia and osteoarthritis. Record review of Resident #150's Comprehensive Care Plan, dated 01/20/2025, reflected that the resident had alteration in musculoskeletal status related to fibromyalgia and one of the interventions was to give analgesics as ordered. Record review of Resident #150's Physician's Order, dated 01/08/2026, reflected Lidocaine External Patch 4% (Lidocaine) Apply to Bilateral Knees topically (applied to the surface of the skin) one time a day related to UNSPECIFIED (continued on next page)		

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 01/22/2026
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	OSTEOARTHRITIS, UNSPECIFIED SITE. Apply QAM and Remove QHS and remove per schedule. Record review of Resident #150's Physician Order on 01/20/2026 reflected resident #150 did not have orders for topical roll-on analgesic and antifungal powder. During an observation and interview on 01/20/2026 at 9:13 AM, revealed Resident #150 was in her bed, awake. It was observed that an antifungal powder and a topical analgesic were on the resident's side table and was on plain view. She said she was not using the medications but they have always been on her side table. In an interview on 01/21/2026 at 11:23 AM, LVN C stated the antifungal powder and the topical analgesic should not be inside Resident #150's room because the resident might use them inappropriately or might use them more than the recommended. She said confused residents might consume them as well that could result to upset stomach and nausea. She said she knew the resident had an order for analgesic patches but not sure if she had orders for antifungal and topical analgesic. She said if there were no orders, she would check if the medications were needed and would request for orders. She went inside the resident's room and saw the medications. She talked to the resident and took the medications. In an interview on 01/22/2026 at 8:23 AM, the DON stated that medications should not be stored inside the residents' rooms unless they have an assessment for self-medication. She said nasal spray, antifungal powder, and topical analgesic should be inside the carts to secure them. She said the staff should be the one administering them if the residents had orders for the said medications. She said the residents might use them inappropriately that could result in adverse reactions. She said the expectation was there would be no medications inside the rooms of the residents and that staff should scan the room for any medications. She said she already started an in-service about medication storage. In an interview on 01/22/2026 at 8:57 AM, ADON B stated that nasal sprays, antifungal powder, and topical analgesics should not be inside the residents' rooms and should be in the carts. She said the medications should be secured so the residents, especially the confused resident, would not get a hold of them and misuse them. She said the staff should be mindful that no medications were inside the rooms. She said this was not only applicable for the nurses but the CNAs must report to the nurse if they saw any. She said the DON already started an in-service about medication storage. In an interview on 01/22/2026 at 9:27 AM, the Administrator stated that the expectation was for the staff to make sure there was no medications inside the resident's rooms because the residents might consume the medications or use them inappropriately. He said he would collaborate with the DON and the ADONs to re-educate the staff about no medications inside the rooms of the residents. Record review of the facility's policy, Medication Administration Policy/Procedure - Nursing Services revised July 2013 reflected POLICY: It is the policy of this facility that medications shall be administered as prescribed by the attending physician . PROCEDURES . 1. Only licensed medical and nursing personnel or other lawfully authorized staff members may prepare, administer, and record the administration of medications. Record review of the facility's policy, Drug Storage Policy/Procedure - Nursing Services revised July 01, 2024 reflected POLICY: It is the policy of this facility to ensure the proper and safe storage of drugs and biologicals . PROCEDURES . 2. Drugs and/or biologicals should not be left unsecured/unattended. Record review of the facility's policy, Physician Orders Policy & Procedure revised November 2022 reflected Policy: It is the policy of this facility that drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs . Procedures . 8. Drugs and biological orders must be recorded on the Physician's Order Sheet in the resident's chart.		

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 01/22/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. Specifically, the facility failed to ensure that the dining area coffee station and ice machines were maintained in a clean and sanitary manner to prevent contamination of food and beverages. These failures could place residents at risk for cross contamination and air-borne illnesses. Findings include: Observations on January 20, 2026 at 9:04 A.M., while approaching the kitchen to conduct the assigned kitchen tour for survey, the surveyor walked through the dining area. Upon entry into the dining area, the surveyor immediately observed the coffee station to be visibly filthy. Spilled coffee was observed on the countertops, on the exterior surfaces of the coffee machine, and on the floor directly in front of the coffee station. The coffee residue was dry, indicating it had been present for an extended period of time and had not been recently cleaned. During continued observation of the facility, one ice machine located in the main hallway was observed to be visibly dirty. Debris was observed on both the interior and exterior surfaces of the ice machine. The ice scoop used for resident service was observed to be visibly soiled, with brown spots and residue present, indicating it had not been properly cleaned or sanitized. In an interview on January 22, 2026 at 9:30 AM, the Dietary Manager stated that coffee stations are expected to be cleaned daily and that ice machines are cleaned on a routine schedule. She stated that the kitchen ice machine is typically cleaned weekly and that the main hallway ice machine is cleaned by maintenance. She stated that if she observed an ice machine or scoop in a visibly dirty condition, the equipment would be drained, sanitized, or replaced prior to reuse. When shown a photo of a dirty ice scoop, she stated she would likely replace it if it appeared in that condition. In an interview on January 22, 2026 at 9:50 AM, a Dietary Aide stated that the coffee machine is cleaned daily and deep cleaned weekly. She stated that ice machines are deep cleaned weekly and that the Dietary Manager typically performs the deep cleaning. When shown a photo of the ice machine, she stated that if she observed it in that condition, she would immediately clean it and notify the Dietary Manager. She stated that cleaning is documented on a log located in the kitchen. In an interview on January 22, 2026 at 9:55 AM, a [NAME] stated that the coffee machine is cleaned every morning and that ice machines are cleaned weekly or as needed. He stated that if mold, debris, or residue were observed in an ice machine, he would unplug the machine, notify the Dietary Manager, and place an out-of-order sign on the equipment until it was cleaned. He confirmed that cleaning activities are documented on a log in the kitchen. In an interview on January 22, 2026 at 10:05 AM, ADMIN stated that dietary sanitation should be monitored daily and that staff are expected to address cleanliness concerns immediately when observed. ADMIN acknowledged that the facility has had prior citations related to food sanitation and stated that corrective actions are monitored through the facility's Quality Assurance and Performance Improvement (QAPI) process on a monthly basis. In an interview on January 22, 2026 at 10:15 AM, the Maintenance Supervisor stated that maintenance cleans the ice machine monthly and that a contracted professional service performs deep cleaning every three months. He stated that the professional service had been on site within the past one to two weeks. He stated that cleaning activities are tracked electronically and agreed to provide documentation of the cleaning log.		

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 01/22/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for four of twelve residents (Residents #73, #29, #36, and #117) reviewed for infection control. 1. The facility failed to ensure CNA K performed hand hygiene while providing incontinent care for Resident #73 on 01/21/2026.2. The facility failed to ensure RN E wore a gown while changing Resident #29's g-tube dressing on 01/20/2026.3. The facility failed to ensure LVN C wore a gown while doing Resident #36's treatment, who had an indwelling catheter (flexible tube inserted into the bladder to remove the urine), on 01/20/2026.4. The facility failed to ensure CNA F wore a gown and pair of gloves while changing Resident #117's linens, who was undergoing dialysis (a medical treatment that removes waste products from the blood), on 01/20/2026. These failures could place residents at risk of cross-contamination and development of infections. Findings include: Resident #73 Record review of Resident #73's Face Sheet, dated 01/21/2025, reflected a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included Parkinson's Disease (movement disorder of the nervous system), hypertension (elevated blood pressure), and atherosclerotic heart disease of native coronary artery (buildup of plaque that leads to narrowed or blocked arteries supplying blood to the heart). Record review of Resident #73's Quarterly MDS Assessment, dated 12/02/2025, reflected moderately impaired cognition with a BIMS score of 12. Section H (Bowel and Bladder) indicated Resident #73 was incontinent of bowel and bladder. Record review of Resident #73's Comprehensive Care Plan, initiated 01/13/2026, reflected he was incontinent of bowel and bladder related to functional decline, decreased mobility, history of urinary tract infection, and diagnosis of benign prostatic hyperplasia (enlarged prostate which can block urine flow from the bladder). Interventions included to use disposable briefs and change as needed, and monitor for signs and symptoms of urinary tract infection. During an observation and interview on 01/21/2026 at 9:27 AM, CNA J and CNA K were preparing to provide incontinent care for Resident #73. CNA K pulled down the front of the brief and cleaned Resident #73. She dropped the wipes into a trash bag near her. CNA J rolled the resident to his left side. CNA K cleaned Resident #73's bottom, removed the soiled brief, and dropped it in the trash bag. CNA K removed the soiled gloves and dropped them into the trash bag. She did not use hand sanitizer. CNA K removed a pair of gloves from the pocket of her scrub top and put them on her hands. She then placed a clean brief under Resident #73 and secured the brief in front. CNA K assisted CNA J to reposition Resident #73 and covered him with the blanket. CNA J and CNA K used hand sanitizer from a pump on the wall to clean their hands. CNA K stated she should have used hand sanitizer when she changed gloves. She stated she normally used hand sanitizer, but she was nervous and forgot. She stated she probably should not have carried gloves in the pocket of her scrub top to use for resident care. She stated it was important to keep from spreading infection. During an interview on 01/21/2026 at 9:41 AM, ADON L stated staff should use hand sanitizer with every glove change. She stated CNA K should have taken a small bottle of sanitizer in the room with her supplies. She stated CNA K should not have used gloves she carried in her pocket. She stated staff would receive in-service training on cross contamination and infection control measures while providing incontinence care. During an interview on 01/21/2026 at 10:30 AM, the DON stated CNA K should have sanitized her hands before applying clean gloves. She stated CNA K should have taken a pair of clean gloves from the box on the wall in Resident #73's room, not from the pocket of her top. She stated they had already begun to provide in-service training. She stated it was important to prevent the spread of germs and infection. Resident #29 Record review of Resident #29's Face Sheet, dated 01/21/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #29's Comprehensive (continued on next page)		

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 01/22/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS Assessment, dated 12/07/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had a feeding tube (medical device that helps deliver nutrition and medication directly to the person's stomach). Record review of Resident #29's Comprehensive Care Plan, dated 11/12/2025, reflected the resident required tube feeding and one of the goals was that the feeding tube insertion site would be free from signs and symptoms of infection. Record review of Resident #29's Physician Order, dated 12/04/2025, reflected CLEANSE G-TUBE STOMA WITH NSS, PAT DRY AND APPLY DRY DRESSING. Observation on 01/20/2026 at 1:50 PM revealed RN E was about to check Resident #29's g-tube site. She washed her hands and put on a pair of gloves. She removed the old dressing to be able to assess the g-tube site. After assessing the site, she removed her gloves, washed her hands, and put on a pair of gloves. After putting on a pair of gloves, she covered the g-tube site with a new dressing. She did not wear a gown when she removed the dressing and when she put on the new dressing. It was observed that there was a sign outside the resident's door that the resident was on EBP and PPE was required because the resident had a g-tube. In an interview on 01/20/2026 at 2:12 PM, RN E stated she should have worn a gown because Resident #29 had a g-tube. She said she forgot to do so. She said a gown was required for residents with g-tubes to prevent spread of infection from resident-to-resident. She said the gown served as a protection from contact with body fluids that might be transferred through the clothes. Resident #36 Record review of Resident #36's Face Sheet, dated 01/21/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with acute kidney failure (kidneys stop working). Record review of Resident #36's Comprehensive MDS Assessment, dated 01/07/2026, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated that the resident had an indwelling catheter. Record review of Resident #36's Comprehensive Care Plan, dated 01/07/2026, reflected the resident had a foley catheter and one of the interventions was to use enhanced barrier precautions. An observation on 01/20/2025 at 9:12 AM revealed LVN C was inside Resident #36's doing a treatment. It was observed that she was leaning on the resident's bed while doing the treatment. She was not wearing a gown. In an interview on 01/20/2026 at 1:27 PM, LVN C stated Resident #36 had a catheter and if she would be doing a treatment that required contact, she should wear a gown to prevent transfer of microorganisms and spread of probable infection. She said she was leaning forward and might have had contact with the resident's bed. She said she put on a pair of gloves but should have worn a gown for an extra layer of protection. Resident #117 Record review of Resident #117's Face Sheet, dated 01/21/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with renal failure. Record review of Resident #117's Quarterly MDS Assessment, dated 12/25/2025, reflected the resident had moderate cognitive impairment with a BIMS score of 10. The Quarterly MDS Assessment indicated that the resident was undergoing hemodialysis (medical treatment that filters waste and excess fluids from the blood when the kidney can no longer function). Record review of Resident #117's Comprehensive Care Plan, dated 01/12/2026, reflected the resident needed hemodialysis and one of the interventions was to monitor signs and symptoms to access site. Record review of Resident #117's Physician Order, dated 12/22/2025, reflected HEMODIALYSIS 3X/WEEK EVERY T-TH-SAT Needs Hemo-dialysis r/t Renal failure End stage renal disease requiring Hemodialysis 3x a week every . EVERY T-TH-S @1100 every shift every Tue, Thu, Sat related to END STAGE RENAL DISEASE (a condition where the kidneys can no longer function adequately); DEPENDENCE ON RENAL (relating to the kidneys) DIALYSIS. PLEASE SEND DIALYSIS BINDER AND SHEET WITH PATIENT, FILL OUT REQUIRED INFORMATION AND WHEN LEAVING AND RETURN. An observation on 01/20/2026 at 9:32 AM revealed that CNA F went inside Resident #117's room with some linens with her. She put on a pair of gloves and started to change the resident's linen. She took off the old linens and replaced them with new ones. She did not wear a gown. There was a sign outside the resident's door that the resident was on enhanced barrier precautions and required PPE. During an interview and observation on 01/20/2026 at 9:34 AM, LVN C (continued on next page)		

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 01/22/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated Resident #117 was on EBP because she was undergoing dialysis. She said CNA F was just changing the linens and was not doing any care. She then read the sign and saw that PPE was required for changing linens. She then went inside the room and told CNA F that she should wear a gown when she changed Resident #117's linens. In an interview on 01/20/2026 at 9:39 AM, CNA F stated she should have worn a gown when she was changing Resident #117's bedding because the resident was on EBP and the signage outside the room clearly indicated to use PPE when changing the linens. She said the resident was not in the bed but she could introduce germs from her scrubs or she could get germs from the bed and transfer them to another resident that she would later have contact with. In an interview on 01/22/2026 at 8:23 AM, the DON stated that when a resident was on EBP, staff should wear a gown and a pair of gloves when handling the resident or the resident's beddings to prevent any transfer of MDROs (Multi-Drug Resistant Organisms: refers to microorganisms that are resistant to one or more antibiotics). She said these organisms might transfer to the scrub suits and then might be transferred to other residents. She also said that there was a sign outside the doors of the residents that were on EBP to remind the staff to wear PPE. She said all the residents with indwelling medical devices, like feeding tube, urinary catheter, and dialysis port, were on EBP. She said the expectation was for the staff to be mindful with what they were doing to protect the residents from all kinds of infections. She said she already initiated an in-service about EBP and infection control and would closely monitor the staffs' adherence to the policy. In an interview on 01/22/2026 at 8:57 AM, ADON B stated that the staff must wear a gown when PPE was required. She said if there was a sign outside a resident's door that the resident was on EBP, then gowns should be worn, in addition to the gloves, for an extra layer of protection from splashes of blood or bodily liquids that could be infected and then could be transferred to other residents. She said the staff might also bring home any infection that adhered to the clothing. She said deviation from the said procedure could result in cross contamination and spread of infection, if there was any. She said the expectation was for the staff to be mindful and compliant with the policy of infection control. She said the DON already started an in-service about EBP and infection control. In an interview on 01/22/2026 at 9:27 AM, the Administrator stated that the expectation was for the staff to adhere to the policy of infection control. He said the staff should wear a gown if the residents were on EBP. He said the staff should always make sure that they were aware that their actions could cause infections. He said, if there was a sign outside the residents' door, the staff should stop and read what was in the signage to see if they needed to wear a gown or not. He said he would collaborate with the DON and the ADONs to re-educate the staff about the importance of wearing PPE when required. Record review of the facility's policy, IPCP Standard and Transmission-Based Precautions undated, reflected Enhanced Barrier Protections (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs). Record review of the facility's signages outside the resident's room who were on EBP reflected Enhanced Barrier Protections. Providers and Staff Must also: Wear gloves and gowns for the following High-Contact Resident Care Activities. Changing Linens. urinary catheter. feeding tube.		

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 01/22/2026
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for two (Resident #81 and Resident #93) of twenty-one residents reviewed for dignity.1. The facility failed to ensure RN E was not standing when assisting Resident #81 with his drinks on 01/20/2026.2. The facility failed to ensure RN E was not standing when assisting Resident #93 with her food on 01/20/2026. These failures could place the residents at risk of not having their right to a dignified existence maintained that could lead to embarrassment. Findings included: 1. Record review of Resident #81's Face Sheet, dated 01/21/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) affecting the left side, and speech deficits following cerebral infarction (insufficient oxygen in the brain causing stroke). Record review of Resident #81's Comprehensive MDS Assessment, dated 12/30/2025, reflected the resident had severe (resident required significant assistance and support in daily life) impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated that the resident required set-up assistance when eating. Record review of Resident #81's Comprehensive Care Plan, dated 01/16/2026, reflected the resident had alteration in muscular status and one of the interventions was to anticipate and meet the needs. An observation on 01/20/2025 at 1:03 PM revealed RN E was walking around the dining area. When she reached Resident #81's table, she picked up the resident's glass and assisted the resident to drink. She was standing when she assisted the resident to have a drink. After giving the resident, a sip of his drink, she continued to walk around the dining area. Observation and interview on 01/20/2026 at 2:09 PM revealed Resident #81 sitting on his wheelchair inside his room. When asked if it was okay for any staff to stand when assisting him for lunch, the resident did not reply.2. Record review of Resident #93's Face Sheet, dated 01/21/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness, dysphagia (difficulty in swallowing), and pneumonia (inflammation and fluid in the lungs caused by a bacterial, viral, or fungal infection). Record review of Resident #93's Comprehensive MDS Assessment, dated 12/03/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated that the resident required set-up assistance when eating. Record review of Resident #93's Comprehensive Care Plan, dated 11/08/2025, reflected the resident had ADL self-care performance deficit and one of the goals was for the resident to maintain his current level of function in eating. An observation on 01/20/2026 at 1:06 PM, after giving Resident #81 a sip of his drink, RN E continued to walk around the dining area. When she reached Resident #93's table, she picked up Resident #93's fork, took a piece of food using the fork, and gave it to the resident. RN E was standing up when she gave the piece of food to the resident. She then walked around the dining area again. In an interview on 01/20/2026 at 1:18 PM, RN E stated that she should be sitting down when assisting somebody in the dining area. She said she assisted Resident #81 and Resident #93 while waiting for somebody to assist them. She said, but still, she should have sat down. She said, when assisting somebody during mealtimes, she should sit down so she would be face to face with the resident. She said standing up was not a way of showing respect and dignity. Observation and interview on 01/20/2026 at 2:19 PM revealed Resident #93 was sitting on her wheelchair inside her room. When asked if it was okay for any staff to stand when assisting her for lunch, the resident did not reply. In an interview on 01/22/2026 at 8:23 AM, the DON stated staff should sit down next to the resident when assisting the residents during mealtimes. She said sitting beside the resident promoted dignity and respect, allowed close observation of the resident's eating habits, and ensured the resident was not in any (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/22/2026
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	distress. She said not sitting beside the resident to assist in eating did not uphold dignity and respect. She said sitting beside the resident also allowed close observation of the resident's eating habits like if the residents were swallowing the food, if there was a problem in swallowing, if the resident was pocketing the food, if the residents were choking. She said the expectation was for all the staff to provide all the residents a dignified existence. She said she already initiated an in-service about dignity and would closely monitor the staffs' adherence to the policy. She said it did not matter if the residents were affected or not but still, the staff should be mindful and think that if they were in the residents' shoes, do they want others to see them exposed and to be assisted by somebody that was standing up. In an interview on 01/22/2026 at 8:57 AM, ADON B stated that the staff assisting a resident during mealtime should be sitting alongside the resident to provide dignity. She said sitting beside the resident would allow better observation of the resident's needs during mealtime. She said sitting beside the resident encouraged interaction and promoted safety when eating. She said the expectation was for the staff to provide dignity, not only during mealtimes but every time the staff provided care to the residents. She said the DON already started an in-service about dignity. In an interview on 01/22/2026 at 9:27 AM, the Administrator stated that staff should not be standing up when assisting the residents in the dining area. He said the expectation was for the staff to always have in mind that the residents have the right for a dignified existence and it should be provided during all interactions with the residents. He said he would collaborate with the DON and the ADONs to re-educate the staff about the importance of providing dignity of the residents. Record review of the facility's policy, Resident Rights Services revised October 04, 2016, reflected As a resident of this nursing facility, you have the right to a dignified existence . Respect and Dignity. You have the right to be treated with respect and dignity.		

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 01/22/2026
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one (Resident #102) of eighteen residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #102 room was in a position that was accessible to the resident on 01/20/2026. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Record review of Resident #102's Face Sheet, dated 01/21/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with convulsions (sudden irregular movement of the body) and muscle weakness. Record review of Resident #102's Quarterly MDS Assessment, dated 12/02/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 10. The Quarterly MDS Assessment indicated the resident was independent for transfer, toileting hygiene, shower, dressing, and bed mobility. Record review of Resident #102's Comprehensive Care Plan, dated 12/16/2025, reflected the resident was at risk for falls related to convulsions and weakness and one of the interventions was to be sure the resident's call light was within reach. Observation and interview on 01/20/2026 at 9:44 AM revealed Resident #102 was in his bed, awake. It was observed that the resident's call light was on the floor at the head of the bed. The resident said he used his call light, but it was nowhere to be found. Observation and interview on 01/20/2026 at 9:49 AM, ADON A stated call lights should always be within reach of the residents because that was how they called the staff if they needed something. He said without the call lights, the residents might be upset or might fall if they tried to do things by themselves. He went inside the resident's room and saw the call light on the floor. He pulled the call light from the floor, put it where the resident could reach it, and told the resident where the call light was. He said whoever checked on the resident should have made sure that the call light was with the resident. He said everybody was responsible in making sure that the call lights were within reach always for all the residents. He said he would start an in-service about call lights. In an interview on 01/22/2026 at 8:23 AM, the DON stated that call lights were inside the residents' rooms so they can call the staff for assistance, a glass of water, pain medication, or because they needed to be changed. She said if the call lights were not within reach, their needs would not be met. The DON said the call lights were for all residents and all the staff were responsible for the call lights. The DON said the expectation was for the staff to scan the residents' room when they did their rounds and ensure the call lights were within reach of the residents before they leave the room. The DON said they already started an in-service about call light placement and would continually educate the staff about the importance of call lights for the residents. In an interview on 01/22/2026 at 9:27 AM, the Administrator stated that call lights should be within the reach of the residents at all times. He said for some residents, the call light was their sense of protection that if something happened to them, they would be able to call the staff for help. The Administrator said the residents might fall trying to get up to get what they needed. He said everybody was responsible in making sure the call lights were with the residents, whether the resident was independent or not. He said he would collaborate with the DON and the ADONs about the issue regarding call lights. Record review of facility's policy Call Light/Bell Policy/Procedure - Nursing Clinical revised May 2020 reflected POLICY: It is the policy of this facility to provide the resident a means of communication with nursing staff. PROCEDURES . 5. Leave the resident comfortable. Place the call device within resident's reach before leaving room.		

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 01/22/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for two of eight residents (Resident #87 and Resident #12) reviewed for care plans. 1. The facility failed to ensure Resident #87's Comprehensive Care Plan reflected oxygen therapy and nebulizer with a breathing mask (used to receive medication by breathing in mist through the nose and mouth).2. The facility failed to ensure Resident #12's Comprehensive Care Plan reflected a BiPAP machine (noninvasive ventilation that helps you breathe). These failures could place the residents at risk of not receiving the necessary care and services needed. Findings include:Resident #87Record review of Resident #87's face sheet, dated 01/22/2026, reflected a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included iron deficiency anemia (the body lacks enough iron to produce healthy blood cells, which carries oxygen throughout the body) and diabetes (elevated blood glucose).Record review of Resident #87's Quarterly MDS (tool used to measure health status) Assessment, dated 12/13/2025, reflected moderately impaired cognition with a BIMS (tool used to measure cognitive status) score of 11. Section O (Special Treatments, Procedures, and Programs) Diagnoses) indicated Resident #87 received oxygen therapy. Record review of Resident #87's Comprehensive Care Plan, dated 12/10/2025, did not reflect oxygen therapy or breathing treatments via nebulizer. Record review of Resident #87's Physician's Orders, dated 12/21/2025, reflected a PRN (as needed) order to administer oxygen 2-3 liters per minute via nasal cannula to keep the oxygen saturation above 92%. Record review of Resident #87's Physician's Orders, dated 12/10/2025, reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 3 ml inhale orally every 6 hours as needed for SOB administer 3ml via nebulizer.Resident #12Record review of Resident #12's face sheet, dated 01/22/2026, reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. He had diagnoses which included acute respiratory failure with hypoxia (sudden decrease of oxygen levels in the blood), diabetes (elevated blood sugar levels), and chronic kidney disease (gradual loss of kidney function).Record review of Resident #12's Quarterly MDS Assessment, dated 12/29/2025, reflected moderately impaired cognition with a BIMS score of 11. Section O (Special Treatments, Procedures, and Programs) indicated Resident #12's respiratory therapy included mechanical ventilation (delivers airway pressure to assist breathing through a mask). Record review of Resident #12's Comprehensive Care Plan, dated 12/10/2025, did not reflect a BiPAP machine. Record review of Resident #12's Physician's Orders, dated 11/24/2025, reflected to use BiPAP at bedtime related to acute respiratory failure with hypoxia. An observation and interview on 01/20/2026 at 9:14 AM revealed Resident #12 lying in bed. A BiPAP with an attached nasal mask (covers only your nose and delivers pressurized air directly through the nasal passage) was on the resident's nightstand. Resident #12 stated he had used a face mask before, but it was too tight, and the nasal mask was more comfortable. He stated he wore it at nighttime.During an interview on 01/22/2026 at 12:26 PM, the MDS Coordinator opened her laptop to review Resident #87 and Resident #12's chart. She stated the respiratory items were not included in the care plans but should have been. She stated it was important for nurses to know the interventions in place to keep the residents safe. The MDS Coordinator stated she was responsible for the care plans of the residents on the hall where Resident #87 and Resident #12 resided. During an interview on 01/22/2026 at 12:35 PM, the DON stated residents should have had respiratory items included in care plan. She stated it was important to monitor and give appropriate care and treatment. She stated care plans allow staff to measure results and determine if care provided was effective. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/22/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/22/2026 at 12:52 PM, ADON B stated she had looked at Resident #87 and Resident #12's care plans and the respiratory items were not included. She stated it was important to be able to look at a care plan and see the resident's history. She stated a resident who admitted to the facility with COPD (disease that restricts breathing) may or may not use oxygen. She stated staff could look at the care plan to see if there was a history of a resident using a BiPAP or if the resident refused to use it. She stated if a resident had an episode of shortness of breath, staff could look at the care plan to see if the resident had a history of respiratory issues. Record review of facility's policy, Comprehensive Care Planning, undated, reflected The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.		

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 01/22/2026
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals that met the needs of each resident for one (LVN D) of three LVNs and reviewed for pharmaceutical services. The facility failed to ensure LVN D did not put and leave her personal beverage on top of the nurse's cart on 01/20/2026. This failure could place residents at risk for potential overdose, adverse effects, cross contamination, and potential interference with medication preparation. Findings included: An observation on 01/20/2026 at 9:35 AM revealed a cup from a coffee shop was on top of a med cart parked in a hallway and was unattended. The cup was left beside the apple sauce that was used during medication administration. During an observation and interview on 01/20/2026 at 9:37 AM, LVN D stated it was her coffee and she should not leave it on top of the cart because it could cause cross contamination and accidentally be mixed with the medications she was preparing. She said a resident might be able to drink it and might get scalds if it was hot. She took the cup and said she would dispose of it. In an interview on 01/22/2026 at 8:23 AM, the DON stated that staff should never put their personal drinks on top of the med carts. She said aside from the risk of cross contamination, some residents might take it and drink its content. She said if the content was hot, the resident might be burned. She said it may contribute also to choking if the resident who drank it was using thickener for his drinks. She said its content might also spill on the medications the staff were preparing. She said it might also spill on the carts, and they needed to replace all the medications that were damaged. She said their policy might not include putting personal beverages on top of the cart, but it was the best practice. In an interview on 01/22/2026 at 8:57 AM, ADON B stated no personal beverages should be on the medication carts because aside from being a clutter, that might contribute to medication error and staff might bring some microorganism from their home or coffee shop to the medication cart. She said the DON already started an in-service about no personal beverages in the carts. In an interview on 01/22/2026 at 9:27 AM, the Administrator stated personal beverages should be in the break room and not on top of the carts because of the danger of hot spillage or contaminating the medications that were being prepared. He said he would collaborate with the DON and the ADONs to re-educate the staff about not having any personal drinks on the cart. Policy for not having any personal beverages on top of the cart requested on 01/21/2026 at 8:17 AM via email to the Administrator but was not provided prior to exit.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/22/2026
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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety for 1 of 6 residents (Resident #102) reviewed for safe smoking. The facility failed to complete a Smoking assessment for Resident #102 upon his admittance to the facility on [DATE]. This failure could place the resident at risk of harming himself when smoking. Findings include: Record review of Resident #102's Face Sheet, dated 01/21/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #102 had acute respiratory failure with hypoxia (low oxygen intake) and a need for assistance with personal care. Record review of Resident #102's Quarterly MDS Assessment, dated 11/08/25, reflected Resident #102 had an intact cognitive response. The Quarterly MDS Assessment reflected the resident had active diagnoses of respiratory failure, congestive heart failure, and tobacco use. Record review of Resident #102's Comprehensive Care Plan, dated 11/08/25, reflected a plan of care for smoking and an intervention was to complete a smoking assessment as needed. Record review of Resident #102's clinical records did not contain a smoking assessment for the resident. In an interview on 01/21/26 at 10:00 AM, the Social Worker was told there was no smoking assessment observed in Resident #102's records. The Social Worker stated the resident should have had an assessment completed when he was admitted to the facility on [DATE] by the admitting nurse and she should have caught it when she completed her audits but it was overlooked. She stated the resident needed a smoking assessment completed to ensure there were no dangers for him. In an interview on 01/22/26 at 8:51 AM, the DON was told about Resident #102 not having a smoking assessment completed. She stated the SW had informed her of this. She stated the SW should have assessed the resident as soon as she found out he was a smoker. She stated if the resident did not receive a smoking assessment, he could harm himself when smoking. Record review of facility's policy, Smoking Policy, undated, reflected The purpose of our policy is to provide maximum safety to all of our residents. We want to provide a safe environment for all residents, as well as accommodate the wishes of those who elect to smoke. This policy applies to all residents who chose to smoke. There will be a smoking assessment of any resident who wishes to smoke on admission by the SW or licensed nurse.		