STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385201	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Post Acute	707 SW 37th Street Pendleton, OR 97801

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review it was determined the facility failed to protect the resident's right to be free from abuse by another resident for 1 of 7 sampled residents (#17) reviewed for abuse. This placed residents at risk for abuse. Findings include:Resident 17 was admitted to the facility in 12/2017 with diagnoses including vascular dementia (impaired reasoning, planning, judgment, memory and other thought processes caused by impaired blood flow to the brain) and peripheral vascular disease (a condition that affects the blood vessels outside of the heart and brain and primarily involves the narrowing or blockage of arteries that supply blood to the legs, arms, stomach, or kidneys).Resident 17's 12/31/24 annual MDS indicated a BIMS was not completed due to her/his refusal to participate in the assessment.Resident 17's cognition care plan indicated she/he refused to participate in a standardized cognitive evaluation and staff were unable to assess her/his level of cognition.Resident 63 was admitted to the facility in 3/2025 with diagnoses including a femur fracture and Alzheimer's disease.Resident 63's 3/13/25 admission / Medicare - 5 Day assessment revealed she/he had severe cognitive impairment and exhibited physical and verbal behaviors on a daily basis. A cognitive loss / dementia CAA completed with her/his admission assessment indicated she/he scratched and hit staff members and her/his goal was to return to a memory care facility after completing her/his therapy goals.A review of Resident 63's care plan revealed staff were to monitor her/him for acts of physical aggression toward staff.A FRI completed on 3/31/25 revealed Resident 63 wandered into Resident 17's room on 3/30/25 and told her/him to get out of her/his bed then pinched Resident 17 on the wrist which caused two small bruises to Resident 17's wrist. The FRI concluded the facility substantiated abuse of Resident 17 by Resident 63.On 4/1/25 Staff 5 (Social Services Director) submitted a written statement with a summary of the incident. In her statement, Staff 5 indicated Resident 17 pointed to the bruises on her/his wrist and stated, Look what that crazy [resident] did and Just keep [her/him] away from me. In her statement, Staff 5 concluded resident-to-resident abuse occurred. On 8/21/25 at 7:45 AM Staff 38 (CNA) stated he remembered the incident and Resident 17 showed him the bruises on her/his wrist the day after the incident. Staff 38 stated he and other CNAs kept Resident 17 and Resident 63 separate after the incident on 3/30/25 to avoid any other incidents.On 8/21/25 at 8:17 AM Staff 5 stated she remembered the incident and staff placed a temporary stop sign on Resident 17's door to discourage Resident 63 from entering without permission and possibly having another incident.On 8/21/25 at 2:57 PM Staff 32 (CNA) stated she remembered the incident and said Resident 63 was pretty aggressive and wandered into Resident 17's room, grabbed her/him and wouldn't let her/him go.On 8/22/25 at 9:09 AM Staff 40 (CNA) stated he remembered the incident on 3/30/25 and heard Resident 17 hollering out and found her/him crying in her/his doorway with Resident 63. Staff 40 stated he helped Resident 63 back to her/his room while a nurse assessed Resident 17. Staff 40 stated Resident 63 swatted at but never hit other residents when she/he was uncomfortable with them. Staff 40 stated Resident 63 did not have a one-on-one at the time of the incident and he did not know if she/he ever had a one-on-on after the incident.On 8/22/25 at 11:32 AM Staff 1 (Administrator) acknowledged the incident on 3/30/25 with Resident 17 and Resident 63. Staff 1 stated all residents should be free from aggressive behaviors, including pinching. Staff 1 stated he expected staff to monitor residents who demonstrate behaviors to limit the possibility of them escalating to the level of abuse.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review it was determined the facility failed to ensure residents were free from misappropriation of resident property for 1 of 1 sampled resident (#26) reviewed for misappropriation of controlled pain medication. This placed residents at risk for unmanaged pain. Findings include:Resident 26 was admitted to the facility in 6/2024 with diagnoses including infection of the abdominal wall.Resident 26's 6/11/25 Annual MDS indicated the resident was cognitively intact.Resident 26's 11/2025 MAR indicated the resident was to have oxycodone 2.5 mg (a Schedule II controlled pain medication) every four hours as needed for pain. The facility's investigation dated 11/20/24 included the following:- During a routine narcotic count it was discovered a card of oxycodone belonging to Resident 26 was missing.- It was determined the CMAs and nurses on the night shift were not counting the narcotic drawer properly.- The facility took immediate action to ensure narcotics were counted correctly.- The facility determined misappropriation of Resident 26's personal property occurred, and the claim was substantiated.On 8/19/25 at 9:39 AM Resident 26 stated she/he had not missed any needed oxycodone doses since admission to the facility, and she/he was not aware of any missing oxycodone. On 8/20/25 at 11:03 AM Staff 16 (CMA) stated while performing a narcotic count at shift change, he noticed a card of oxycodone was missing for Resident 26. Staff 16 stated they had reported the incident to a nurse, and the card was not found. On 8/20/25 at 12:17 PM Staff 3 (RNCM) stated a card of Resident 26's oxycodone was missing and not found. Staff 3 stated an investigation was conducted and concluded the narcotic drawer was not counted properly, and the card was likely thrown away by mistake. Staff 3 stated a corrective plan was implemented over the following six weeks. The deficient practice was identified as Past Noncompliance based on the following:On 11/21/24 the deficient practice was identified and corrected with the following actions:1. Education and demonstration regarding proper narcotic counting was given to all CMAs. 2. All CMAs and nurses attested to having reviewed the PharMerica instruction manual regarding the procedure for pulling controlled medications for administration and maintaining the narcotic record book.3. Weekly narcotic count audits were completed by the DNS for six weeks.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure there was sufficient nursing staff available to provide the necessary care and services to meet residents' needs in 1 of 1 facility reviewed for staffing. This placed residents at risk for lack of ADL care needs. Findings include: On 8/18/25 the facility had a census of 53 residents. On 8/20/25, Staff 1 (Administrator) provided a list of residents who:-Required two-person mechanical lift transfers: 12;-Required two-person extensive or total assistance for bathing: 1; -Required two-person extensive or total assistance for toileting: 10;-Required two-person extensive or total assistance for dressing: 1;-Required one-to-one feeding assistance: 7;-Were considered high fall risks: 30;-Were considered at risk for elopement: 4 and -Required bariatric care (body mass index greater than 40): 10. 1. Resident 3 was admitted to the facility in 3/2025 with diagnoses including a stroke and dysphagia (difficulty swallowing foods and liquids). Resident 3's 3/18/25 admission MDS indicated the resident had severe cognitive impairment and was dependent for all care needs including toileting and bed mobility. Resident 3's 6/7/25 fall investigation report indicated the resident had a fall on 6/7/25, night shift and only two CNA staff were on shift when Resident 3 fell. On 8/18/25 at 3:54 PM and 8/19/25 at 2:22 PM, Witness 2 (Family Member) stated the facility did not usually have enough staff scheduled and on 6/7/25 night shift, when Resident 3 fell, the facility was short-staffed. On 8/20/25 at 8:58 AM, Staff 27 (CNA) reported he worked on 6/7/25 with Staff 26 (CNA) and stated two CNAs were not enough staff to meet the needs of the residents because the facility is big and the acuity of the residents was too high for only two CNA staff. On 8/20/25 at 9:10 AM, Staff 26 stated on 6/7/25 there were only two CNAs working in the facility for 50 residents thus they were not able to meet the acuity needs of the residents. On 8/21/25 at 11:12 AM, Staff 2 (DNS) and Staff 3 (RNCM) verified on 6/7/25, the facility only had two CNA staff on night shift, and confirmed the facility was short-staffed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Random observations from 8/18/25 through 8/22/25 between the hours of 7:30 AM and 10:00 PM revealed the following: -No call light monitors were observed in the residents' units/hallways. There was one call light monitor located at the nurses' station which was inaudible. On 8/19/25 at 2:54 PM, the call light monitor at the nurses' station was not functioning. -On 8/19/25 at 2:54 PM, room [ROOM NUMBER]'s call light was activated for 34 minutes and room [ROOM NUMBER]'s call light was activated for 30 minutes. -CNA staff were to carry electronic call light activation devices, and some CNAs did not have electronic call light activation devices on their person when randomly asked to produce the device.-On multiple occasions during day and evening shift observations, CNA staff were difficult to find. -On 8/19/25 at 3:01 PM, a resident on the 200 unit was visible from the hallway, naked and was hollering, gotta moment? Multiple staff walked by the resident's room without stopping to assist the resident. -On 8/20/25 at 8:22 PM, a resident was outside in the parking lot with a CNA, yelling help me, help me, help me. -On 8/20/25 at 8:33 PM, room [ROOM NUMBER]'s call light was activated for 47 minutes, room [ROOM NUMBER]'s call light was activated for 30 minutes, room [ROOM NUMBER]'s call light was activated for 28 minutes and room [ROOM NUMBER]'s call light was activated for 22 minutes. -On 8/20/25 at 8:55 PM, two residents were in wheelchairs on the 300 unit and verbalized they were waiting for assistance to go to bed for at least 45 minutes. On 8/18/25 at 9:45 AM, Resident 26 stated she/he required two staff to assist with all ADL care. Resident 26 stated it took anywhere from 30 minutes to two hours to find two staff available to assist with her/his ADL care. Resident 26 stated the night shift was the worst shift. On 8/18/25 at 11:03 AM, Resident 20 stated she/he was incontinent and sometimes it took what feels like hours before staff were available to assist her/him. On 8/18/25 at 1:13 PM, Resident 4 stated call light response times were frequently slow, especially during mealtimes. Resident 4 stated she/he sometimes waited up to two hours for assistance. Resident 4 stated she/he feared something might happen to her/him and nobody would be available to help. On 8/18/25 at 1:21 PM, Resident 18 stated last week it took staff 58 minutes to assist her/him. Resident 18 stated staff often answered her/his call light, said they would be right back and never returned. On 8/20/25 at 9:41 AM, Staff 22 (CNA) stated the facility had many CNA staff who called off, frequently. Staff 22 stated the facility was chronically low staffed which resulted in residents' not receiving proper care. Staff 22 stated during times when the facility was short staffed, residents' showers were missed, call light response times were longer, and staff had to stay past their shift to complete all of their work. On 8/20/25 at 10:18 AM, Staff 15 (RN) stated there were often days when CNAs called off or were habitually late which resulted in inadequate staffing. Staff 15 stated the facility did not staff according to the acuity needs of residents. On 8/20/25 at 10:45 AM, Staff 28 (CNA) stated staffing was horrible and there was often not enough staff scheduled to meet the acuity needs of the residents. Staff 28 stated there was a resident with behavioral needs who often tried to get out of the facility or tried to kiss other residents so the resident required a lot of time to supervise. Staff 28 stated there were times when showers were missed, CNA staff could not complete their rounds or turn residents every two hours and staff were unable to take lunches or breaks. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/25 at 8:43 PM, Staff 32 (CNA) stated care was difficult at times due to the number of bariatric residents. On 8/20/25 at 9:30 PM, Staff 35 (CMA) stated staffing on the weekends was the worst. Staff 35 stated call light response times were often long because CNAs were unable to get to them timely. Staff 35 stated there were a lot of behavioral need residents and residents at a high risk for falls. Staff 35 stated showers were missed, at times. On 8/21/25 at 10:01 AM, Staff 25 (Regional Director of Rehabilitation) confirmed some residents did not receive SLP and OT rehabilitation services timely or at the frequency determined to be necessary because they did not have adequate SLP and OT staff coverage. On 8/21/25 at 11:35 AM, Staff 11 (Human Resources/Payroll/Staffing) stated she was responsible for staffing and staffing needs were based on the State mandatory minimum CNA staffing ratios and not according to the acuity needs of residents. Staff 11 stated she was aware the facility resident acuity levels were high. Staff 11 stated many staff called off and it was difficult to get agency coverage. Staff 28 confirmed the facility was not able to staff to the acuity needs of the residents because they did not have enough employees and agency staff were not available. Staff 28 also verified weekend staffing was especially difficult. 3. Resident 30 was admitted to the facility in 2024 with diagnoses including a stroke and anxiety. A 5/13/25 Annual MDS revealed Resident 30 had a BIMS score of 15, which indicated she/he was cognitively intact, had an indwelling catheter and an ostomy (an appliance worn over the stoma, which is a surgically created opening on the abdomen surface to collect feces). On 8/18/25 at 2:16 PM, Resident 30 stated she/he required assistance with ostomy care and on multiple occasions, her/his ostomy bag had blown out due to insufficient staffing, resulting in a mess on her/him and while in bed. Resident 30 stated she/he was upset and frustrated because there is never enough staff on evening shift. On 8/19/25 at 10:02 AM, Staff 18 (CNA) stated Resident 30 required assistance with the resident's ostomy care and at times the resident's ostomy bag had blown out due to staffing shortages. On 8/20/25 at 1:51 PM, Staff 23 (CNA) stated Resident 30 required assistance with ostomy care and there had been instances when staff were unable to get to respond in a timely manner, resulting in the resident's bag exploding. Staff 23 stated the resident voiced concerns within the past two weeks regarding inadequate ostomy care during evening shift. On 8/20/25 at 7:00 PM, Staff 19 (RN) stated Resident 30 was particular about her/his ostomy care due to concerns about odor and fear of leakage or bursting. Staff 19 stated within the past last two weeks, the resident's ostomy bag exploded during the evening shift due to lack of staff. Staff 19 stated Resident 30 was very upset after experiencing a bowel movement all over herself/himself and in her/his bed. Staff 19 stated this was a direct result of inadequate staffing based on resident acuity. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 8/20/25 at 8:36 PM, Resident 30 was observed in her/his motorized wheelchair just outside her/his doorway and stated her/his call light was on for approximately 20 minutes and the resident was waiting for assistance to go to bed. Resident 30 stated there never was enough staff on evening shift. At 9:11 PM (approximately 60 minutes later) Staff 33 (CNA) assisted the resident to bed. On 8/21/25 at 2:42 PM, Staff 3 (RNCM) stated she was unaware of Resident 30's concerns regarding timely ostomy care. Staff 3 stated staff were expected to answer call lights within five to 10 minutes. Staff 3 acknowledged ongoing staffing challenges and confirmed the facility had residents with high acuity needs. On 8/22/25 at 9:34 AM, Staff 2 (DNS) stated she expected all staff to respond to call lights within 15 minutes and acknowledged the facility struggled to maintain appropriate staffing levels. Staff 2 acknowledged many residents with high acuity care needs. 4. Resident 9 was admitted to the facility on 6/2025 with diagnosis including Parkinsons and difficulty walking. The Dementia Cognitive Loss CAA dated 6/11/25 revealed Resident 9 had severe cognitive impairment and metabolic encephalopathy (the brain is not functioning properly due to a chemical imbalance.) On 8/20/25 at 2:32 PM, Staff 24 (CNA) and Staff 28 (CNA) both stated Resident 9 was a fall risk, experienced confusion, required two-person assistance with transfers and was dependent on staff for all ADL care needs. Staff 24 and Staff 28 indicated the facility was often severely understaffed during evenings and weekends and both were assigned beyond the state minimum staffing ratios. On 8/20/25 at 8:33 PM, Resident 9 was observed up in her/his wheelchair sitting outside her/his room. At 8:45 PM, Staff 31 (LPN) spoke with Resident 9 who stated she/he needed to use the bathroom and wanted to go to bed. Staff 31 requested assistance for Resident 9 and was informed the assigned CNA was providing a shower to another resident. At 9:16 PM, two staff members assisted Resident 9 into her/his bedroom and closed the door. At 9:33 PM, (approximately 45 minutes later), the resident was in bed, with the bed in the lowest position and call light within reach. On 8/20/25 at 9:36 PM Staff 47 (CNA) stated evening shifts were rough. Staff 47 stated it was difficult assisting residents and responding to call lights in a timely manner. Staff 47 stated residents were upset due to long wait times and inadequate staffing. Staff 47 stated multiple residents in the facility required two-person assistance or were fully dependent on staff for ADL care needs. On 8/21/25 at 2:42 PM, Staff 3 (RNCM) stated staff were expected to answer call lights within five to 10 minutes. Staff 3 acknowledged staffing concerns and the facility had residents with high acuity needs. On 8/22/25 at 9:34 AM, Staff 2 (DNS) stated she expected all staff to answer call lights within 15 minutes and acknowledged the ongoing challenges in maintaining appropriate staffing levels. Staff 2 acknowledged the facility had many residents with high acuity care needs. 5. During a Resident Council meeting on 8/20/25 at 1:05 PM, attendees expressed concerns regarding long response times from staff during the evening shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident Council meeting minutes from 5/22/25 concerns with call lights not being answered and staff not coming back after initial response. Resident Council meeting minutes from 6/2025 revealed concerns with staff taking two hours to answer call lights. On 8/22/25 at 9:34 AM, Staff 2 (DNS) stated she expected all staff to answer call lights within 15 minutes and acknowledged the ongoing challenges in maintaining appropriate staffing levels. Staff 2 acknowledged the facility had many residents with high acuity care needs.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on observation, interview and record review it was determined the facility failed to provide physical, occupational and speech therapy services as ordered for 3 of 3 sampled residents (#s 3, 26 and 60) reviewed for rehabilitation services. This placed residents at risk for a decline in functional abilities and diminished quality of life. Findings include: The Stroke Foundation, What to Expect From a Stroke, dated 2023, explained stroke rehabilitation (PT, OT and SLP) was the therapy and activities that drive recovery by helping to re-learn ways of doing things affected by a stroke. It aimed to stimulate the brain to change and adapt. By creating new pathways, a person could learn to use other parts of the brain to recover function of those parts affected by the stroke. Improvement after a stroke can continue for years but for many people it's quickest in the first six months. 1. Resident 3 was admitted to the facility in 3/2025 with diagnoses including a stroke, hemiparesis/hemiplegia (the loss of ability to move part or most of the body) and dysphagia (difficulty swallowing foods and liquids). Resident 3's 3/12/25 Hospital Discharge Summary indicated the resident had a stroke which resulted in a prolonged hospitalization complicated by dysphagia. On 3/7/25, Resident 3 had a PEG tube (a type of feeding tube inserted into the stomach and used for individuals when unable to swallow food or liquids) surgically placed due to her/his inability to swallow. Resident 3's 3/12/25 Discharge to Facility Physician Order's prescribed SLP and OT evaluations and treatment upon admission to the facility. The resident continued to require PEG tube feedings for nutrition. Resident 3's 3/18/25 admission MDS indicated the resident had severe cognitive impairment, was unable to eat by mouth and was dependent for all needed care. Resident 3's Speech Therapy Medicare SLP Evaluation and Treatment revealed the resident was evaluated on 3/28/25, 16 days after the resident was admitted to the facility. The evaluation determined Resident 3 needed SLP treatment two times a week. Resident 3's 3/2025 and 4/2025 SLP Service Matrix Log (a record used to track therapy visits) indicated the resident did not receive her/his twice weekly SLP therapy on 4/5/25 through 4/11/25 and 4/12/25 through 4/18/25. The resident was not provided the prescribed SLP treatments on two of four weeks during 4/2025. Resident 3's Occupational Therapy Medicare OT Evaluation and Treatment revealed the resident was evaluated on 3/31/25, 19 days after the resident was admitted to the facility. The evaluation determined Resident 3 needed OT treatment two times a week. Resident 3's 3/2025 and 4/2025 OT Service Matrix Log indicated the resident did not receive her/his twice weekly OT therapy on 4/6/25 through 4/13/25 and 4/14/25 through 4/20/25. The resident was not provided the prescribed OT treatments on two of four weeks during 4/2025. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiple random observations from 8/17/25 through 8/22/25 between the hours of 7:30 AM and 10:00 PM revealed Resident 3 had right-sided hemiparesis with reduced functional movement of her/his right arm or hand and reduced movement of her/his right leg. Resident 3 had a PEG tube in place. On 8/18/25 at 3:54 PM, Witness 2 (Family Member) reported Resident 3 did not receive timely SLP or OT services as ordered because the facility lacked therapy staff. On 8/21/25 at 10:01 AM, Staff 25 (Regional Director of Rehabilitation) reviewed Resident 3's SLP and OT therapy services for 3/2025 and 4/2025. Staff 25 confirmed the resident did not receive SLP and OT services in a timely manner and at the frequency determined to be necessary because they did not have adequate SLP and OT staffing. On 8/22/25 at 10:09 AM, Staff 1 (Administrator) confirmed Resident 3's SLP and OT services were not provided as prescribed, and he expected therapy to be provided as ordered and in a timely manner. 2. Resident 26 was admitted to the facility in 6/2025 with diagnoses including chronic pain syndrome and bilateral hip arthritis. Resident 26's 6/11/25 Annual MDS indicated the resident had no cognitive impairment. Resident 26 required substantial/maximal assistance for toileting, dressing, personal hygiene, bed mobility and was dependent for chair to bed transfers. A 7/6/25 Progress Note indicated Resident 26 was transferred to the hospital due to nausea, a headache and shoulder pain. A 7/11/25 Progress Note indicated Resident 26 returned from the hospital. Resident 26's 7/11/25 Skilled Nursing Facility Transfer Orders prescribed PT and OT evaluation and management. A review of Resident 26's electronic health record revealed no evidence PT and OT evaluations were completed. On 8/18/25 at 9:45 AM, Resident 26 stated she/he was supposed to receive therapy services, did not receive them and was unsure why no therapy was provided. On 8/21/25 at 10:01 AM, Staff 25 (Regional Director of Rehabilitation) confirmed Resident 26 had PT and OT orders written on 7/11/25 and no PT or OT services were provided. Staff 25 was unsure why the PT and OT orders were missed. 3. Resident 60 was admitted to the facility in 2/2024 with diagnoses including hemiplegia (paralysis of one side of the body) and aphasia (loss of the ability to speak or understand spoken language as a result of brain damage). Resident 60's 2/29/24 admission MDS revealed he was cognitively intact, usually understood speech, sometimes made herself/himself understood, received 26-50% of her/his nutrition and hydration via feeding tube, used a wheelchair for ambulation and was dependent for transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385201	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Post Acute	707 SW 37th Street Pendleton, OR 97801

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 60's signed orders dated 2/26/24 revealed she/he was to be evaluated and treated as necessary by Physical Therapy (PT) and Occupational Therapy (OT). Orders dated 3/5/24 also revealed she/he was to be evaluated and treated as necessary for diet advancement by a Speech-Language Pathologist (SLP). Resident 60's care plan included a goal dated 2/23/24 to work with therapies to increase strength and reinforce cognitive strategies. Resident 60's therapy evaluation notes revealed she/he was evaluated by PT, OT and SLP who recommended the following therapy schedules:-PT: three days per week-OT: five days per week-SLP: three days per week Resident 60's therapy schedule for the week of 2/25/24 through 3/2/24 revealed the following:-Received two of three PT sessions-Received one of five OT sessions-Received two of three SLP sessions Resident 60's therapy schedule for the week of 3/3/24 through 3/9/24 revealed the following:-Received one of three PT sessions Resident 60's therapy schedule for the week of 3/10/24 through 3/16/24 revealed the following:-Received two of three PT sessions On 8/20/25 at 10:29 AM Staff 13 (Administrative Assistant / Director of Rehabilitation) acknowledged the missed therapy dates and stated PT was out sick during the weeks of 2/25/24 through 3/2/24 and 3/10/24 through 3/16/24 and was not able to complete the scheduled sessions. Staff 13 was unaware of the reason for the other missed therapy sessions. On 8/21/25 at 10:12 AM Staff 25 (Regional Director of Rehabilitation) acknowledged the missed therapy sessions and lack of documentation regarding the reason the sessions were missed. He stated therapists sometimes documented in the electronic record and sometimes they did not. On 8/21/25 at 3:09 PM Witness 6 (Family Member) stated Resident 60 was supposed to receive therapy every day and the staff guaranteed Resident 60 would receive therapy three to four days a week. On 8/22/25 at 11:32 AM Staff 1 (Administrator) acknowledged Resident 60's missed therapy sessions and stated he expected all residents to receive skilled therapy as ordered. Refer to F725.