

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Willowbrook Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure a resident did not self-administer non-prescribed medications for 1 of 3 sampled residents (#2) reviewed for medications. This placed residents at risk for incorrect medication administration. Findings include: Resident 2 admitted to the facility in 5/2024 with diagnoses including hemiplegia (one-sided paralysis). Resident 2's 11/13/25 Self-Medication Administration Evaluation indicated she/he was not appropriate to self-administer any medications. Observation on 3/19/26 at 7:50 AM, with Staff 7 (RNCM) observed open tubes of antifungal cream, anti-itch cream, hydrocortisone cream, and a medicated pain roll-on (DMSO) located in Resident 2's bedside table drawer. Review of Resident 2's clinical record found no physician orders for the anti-itch cream, hydrocortisone cream or DMSO. Resident 2 did not have an order to self-administer the medications. On 3/19/26 at 7:50 AM, Staff 7 stated Resident 2 did not have an order to for any of the medications observed in the resident's bedside table drawer. On 3/19/26 at 8:10 AM, Resident 2 stated she/he did self-administer the medications found in her/his room.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure the resident was adequately monitored, had an adequate indication for use, and physician orders for medications for 1 of 3 sampled residents (#2) reviewed for medications. This placed residents at risk for adverse medication side effects of unnecessary medications. Findings include: Resident 2 admitted to the facility in 5/2024 with diagnoses including hemiplegia (one-sided paralysis). Resident 2's 11/13/25 Self-Med Administration evaluation indicated she/he was not appropriate to self-administer any medications. An observation on 3/19/26 at 7:50 AM, with Staff 7 (RNCM) observed an open tube of anti-itch cream, hydrocortisone cream, and a medicated pain roll-on (DMSO) in Resident 2's bedside table drawer. Review of Resident 2's clinical record found no evidence of physician orders, indication of use, or monitoring for the anti-itch cream, hydrocortisone cream and the DMSO. On 3/19/26 at 7:50 AM and 9:03 AM, Staff 7 stated Resident 2 did not have an order for the anti-itch cream, hydrocortisone cream or DMSO, and staff did administer or monitor for the medications. On 3/19/26 at 8:10 AM, Resident 2 stated she/he self-administered the medications found in her/his room.</p>