

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  04/21/2026
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to notify the resident's representative of the resident's transfer from the facility for 1 of 3 residents reviewed for change of condition (#3). This placed residents and residents' representatives at risk for not being able to contact each other. Findings include: Resident 3 admitted to the facility in 2/2026 with a diagnosis including respiratory failure. On 3/28/26 at 7:46 AM, Staff 14 (LPN) documented a progress note that Resident 3 was sent to the hospital at his/her request for not feeling well. There was no documented evidence that Resident 3's representative was notified of the transfer. On 4/21/26 at 10:08 AM and 2:52 PM, attempts to interview Staff 14 were unsuccessful. On 4/20/26 at 2:39 PM, Witness 1 (Family Member) stated the facility did not notify her of Resident 3's transfer to the hospital. She stated they were notified on 3/29/26 by a neighbor, who was contacted by the hospital. On 4/21/26 at 3:02 PM, Staff 2 (DNS) stated the facility did not notify Resident 3's representative of her/his transfer to the hospital and should have. The deficient practice was identified as past noncompliance based on the following: On 3/30/26 the deficient practice was identified by the facility when the facility completed a root cause analysis of the incident and determined the notification was not completed. Correction included: 1. Staff educated on notification policy for changes of condition; 2. All staff were educated on the use of an approved phone script to ensure accurate and appropriate communication; and 3. The phone script was posted by all phones for ease of use.</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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