STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455700	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Nursing Center	227 Russell Blvd Nacogdoches, TX 75965

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** 46273 Based on observations, interviews, and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as possible for 4 of 19 residents reviewed for quality of care. (Resident #3, #58, #86, and #111). The facility failed to remove worn and damaged mechanical lift slings from service. This deficient practice could result in a loss of quality of life due to injuries. Findings included: Record review of a facility face sheet dated 6/18/24 for Resident #3 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: type 2 diabetes (uncontrolled blood sugar), dementia (deterioration of memory, language, and other thinking abilities), and hypertension (high blood pressure). Record review of a comprehensive MDS assessment dated [DATE] for Resident #3 indicated that she had a BIMS score of 4, which indicated that she had severe cognitive impairment. Section GG indicated that she was dependent with transfers. Record review of a comprehensive care plan initiated on 10/13/2020 for Resident #3 indicated that she had an ADL self-care performance deficit. Interventions included .TRANSFER: The resident requires staff assistance with transfers . and Last Care Plan Review Completed section read .4/07/2024 . Record review of a facility face sheet dated 6/18/24 for Resident #58 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: peripheral vascular disease (poor circulation to the extremities), anxiety disorder, and type 2 diabetes (uncontrolled blood sugar). Record review of a quarterly MDS assessment dated [DATE] for Resident #58 indicated that she had a BIMS score of 15, which indicated that she had no cognitive impairment. Section GG indicated that she was dependent with transfers. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a comprehensive care plan initiated on 4/15/20 indicated that Resident #58 had an ADL self-care performance deficit with an intervention that read .TRANSFER: The resident requires Mechanical Aid lift with sling for transfers . Record review of a facility face sheet dated 6/18/24 for Resident #86 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: dementia (deterioration of memory, language, and other thinking abilities), cerebral infarction (stroke), and hypertension (high blood pressure). Record review of a quarterly MDS assessment dated [DATE] for Resident #86 indicated that she had a BIMS score of 4, which indicated that she had severe cognitive impairment. Section GG indicated that her ability to transfer to and from a bed to a chair (or wheelchair) was not applicable meaning that it had not occurred in the previous 7 days. Record review of a comprehensive care plan initiated on 03/12/2024 and revised on 5/8/24 for Resident #86 indicated that she had suffered a Cerebral Vascular Accident (Stroke) and interventions included: activity as tolerated; out of bed in chair if tolerated. Comprehensive care plan did not specifically address ADL needs and supervision required. Record review of a facility face sheet dated 6/17/24 indicated Resident #111 was a [AGE] year-old female and admitted to the facility on [DATE] with diagnosis cerebrovascular disease (blood flow is affected in the brain). Record review of an admission MDS assessment dated [DATE] indicated Resident #111 could not complete BIMS assessment and was dependent with all ADL's. Record review of a comprehensive care plan dated 6/18/24 indicated Resident # 111 had a stroke and required transfer by two persons using a Hoyer lift. During an observation on 6/17/24 at 12:00 pm Residents #3, #58, and #86 were all observed up in the dining room with mechanical lift slings underneath them. Resident #3's lift sling labels appeared to have been cut off as there was evidence of a label being there, but only a thin strip of the white label was remaining showing from the outer edge seam, and the straps were faded to a light purple, light green & light blue (almost gray). Unable to determine brand of Resident #3's sling. Resident #58's lift sling was a blue mesh sling, the colors on straps were faded, all almost gray and the label was unreadable, appeared to be an Invacare brand. Resident #86's lift sling was observed with faded coloring to straps. During an observation on 06/17/24 at 9:01 AM Resident # 111's sling lift pad under her had faded loops. During an observation on 06/18/24 at 8:48 AM Resident # 111's sling lift pad under her had faded loops. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 6/18/24 at 9:18 am Resident #86 was observed up in common area in a Geri chair with a mechanical lift sling underneath her. Sling was a blue mesh and straps were faded in color, they were observed to be light pink and almost gray in color. DON said that she did not know color fading meant sling should not be used. She said they had plenty of slings so she would get them replaced. She said CNAs should be checking the slings for safety before using them. She said if a strap broke, a resident could be at risk for falls. During an observation on 06/18/2024 at 10:41 am CNA C and CNA D were observed transferring Resident #111 by mechanical lift. During an interview on 06/18/24 at 10:41 AM CNA C said that Hoyer slings should be inspected before using and should not be used if they were faded or frayed. She said she had received training on reporting slings that needed to be removed from service. She said that she got Resident #111 up this morning, and she should have gotten a different sling because an old sling could result in a fall or injury. During an interview on 6/18/24 at 3:00 pm Laundry Aide said that she had been employed for approximately one year. She said she did not use bleach on the lift slings. She said she washed them with blankets. She said she checked the slings for loose seams and any rips or tears. She said if she noticed any, she removed slings and did not send them to be used. She said she did not know to watch for color fading. During an interview on 6/19/24 at 4:25 pm Admin said he would be implementing a form to do a weekly lift sling check and would also start dating the slings, so they know how old they are. He said it could be a safety concern if worn lift slings were used. Record review of a facility policy titled Lifting Machine, Using a Portable dated 2001 and revised in April 2007 indicated that it did not address inspecting slings for wear and tear. Record review of manufacture guidelines Full Body Slings - Instructions for use accessed at www.medline.com on 6/18/24 read .Always inspect slings prior to each use. Signs of rips, tears, or frays indicate sling wear which is unsafe and could result in injury. Signs of color fading, bleached areas, or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury. Any slings with signs of wear or improper laundering should be immediately removed from use . and .Do not remove sling labels. If sling labels are removed or no longer legible, sling must be immediately removed from use . Record review of manufacture guidelines Invacare Patient Sling Reference Guide accessed at www.invacare.com on 6/18/24 read .Inspect sling before each use for wear, tears, and loose stitching. Bleached, torn, cut, frayed or broken slings are unsafe and could result in injury. Discard immediately . 46436

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46436 Based on observation, interview and record review, the facility failed to ensure nurse staffing data was posted and readily accessible to residents and visitors with all required information for nurse staffing information. The facility failed to ensure the daily staffing information was posted on 6/17/2024. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. Findings: During an observation on 6/17/2024 at 8:45 am there was no posting observed for nurse staffing information in the facility. During an observation on 6/17/2024 at 11:40 am there was no posting observed for nurse staffing information in the facility. During an interview on 06/17/24 at 11:48 am the staffing coordinator said he posted the working schedule on the bulletin board each day but had not been posting the nurse staffing information for each discipline and was not aware he had to. He said the previous staffing coordinator trained him and he could see if the posting was not posted and visible for residents and visitors, they could think there were not enough staff present to provide care. He said he would correct the data posting and place the posting on the wall. During an interview on 06/17/24 at 12:17 pm the DON said the staffing coordinator was responsible for posting the staffing information and she should have been ensuring that it was posted. She said the ADON would now be responsible for posting the staffing information in a clear and visible area daily. She said they would also start a binder to store the information for 18 months per the regulation. She said by not having the information posted residents and visitors might not think there was sufficient staff present to provide care. During an interview on 06/17/24 at 2:02 pm the administrator said the staffing coordinator was responsible for posting the nurse staffing information and thought the schedule on the bulletin was appropriate. He said he was not sure when the last time the nurse staffing information was posted but would correct the problem and place the sign per the regulations today. He said he did not see any risk to the residents. He said there was no policy for nurse staffing information.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 47339 Based on observation, interview and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition, for 1 of 1 three compartment sink in the kitchen reviewed for food service in that: On 6/17/2024 the facility did not ensure the 3-compartment sink was in working order. The right sink of the 3-compartment sink was leaking water into a tub underneath and onto the floor. This failure could place residents who eat out of the kitchen at risk for food borne illnesses. Findings included: During an observation on 06/17/24 at 08:55 AM revealed: The right side of the main 3 compartment sink was leaking water into a tub sitting on the floor underneath the sink, with a large puddle of soapy water on the floor around the sink area. During an observation and interview on 06/17/24 at 08:59 AM, The DM said he did not know how long the tub had been under the sink, but he removed the tub and took it outside. The DM said the Maintenance Director had fixed the sink last week because it was leaking. He said he did not know how long the sink had been leaking. During an interview on 06/17/24 at 09:05 AM, the cook said she had not noticed the tub on the floor under the sink and did not know how long the sink had been leaking. During an interview on 06/19/24 at 09:42 AM, the DM said he had reported the leaking sink to the Maintenance Director on 6/12/2024. He said the cook had placed the tub under the sink to catch the leaking water on the morning of 6/17/2024. During an interview on 06/19/24 at 09:42 AM, the Maintenance Director said he had put new plumbers' putty and strainer basket on the sink on 6/12/2024. He said there was a tub under the sink to catch the leaking water before and it was still there after he fixed the sink. The Maintenance Director said he had problems with the sink leaking before but was not aware that the sink had still been leaking after he had fixed it on 6/12/2024. During an interview on 6/19/2024 at 04:06 PM The administrator said it was the responsibility of the Maintenance Director to make sure equipment is in good working order. He said the DM was responsible for reporting all needed repairs to the Maintenance Director so they could be repaired. The Administrator said the sink leaking water onto the floor could cause an accident in the kitchen. Record review of the facility policy titled Equipment dated 9/2017 indicated: .5. The Dining Services Director will submit requests for maintenance or repair to the Administrator and/or Maintenance Director as needed. 6. The Dining Services Director will notify the Administrator when repairs are completed. 7. Copies of service repairs and preventative maintenance reports will be submitted monthly.