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	03/19/2025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 47339 Based on interviews and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible; and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 7 (Resident #1) residents reviewed for supervision. The facility failed to notify the transport staff Resident #1 resided on the secure unit and had a diagnosis of dementia. The facility failed to ensure adequate supervision was provided during transport for Resident #1 who resided on the secure unit. On 2/19/25 Resident #1 was left unattended in the transport van for approximately 15 minutes in which Resident #1 eloped out of the van and walked down the road 2 blocks and was picked up by a good Samaritan. Resident #1 was located by the police department about 30 minutes later and returned to the facility. An IJ was identified on 3/18/2025. The IJ template was provided to the facility on [DATE] at 12:45 PM. While the IJ was removed on 3/19/2025, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm because (e.g.) all staff had not been trained on the facilities transportation policy. This failure could place residents at risk of not being properly supervised resulting in injury or death. Findings included: Record review of Resident #1's facility's electronic face sheet dated 3/18/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of dementia (problem with memory, thinking, and reasoning), non-ST elevation myocardial infarction (heart attack), and hypertension (high blood pressure). Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 03 which indicated severe cognitive impairment. He required set up assistance with walking 150 feet. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455700	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan dated 7/9/2024 revealed Resident #1 had impaired safety awareness (behaviors) and resided in the secure unit with interventions that included: 1. Encourage family/support system to actively participate in care. 2. Prioritize activities and offer choices that allow control and meet personal goals for socialization. Record review of Resident #1's admission elopement risk assessment dated [DATE] at 3:15 AM revealed he was at risk for elopement or wandering. Record review of nursing progress note dated 2/19/2025 at 12:38 PM written by LVN O revealed Resident #1 left the facility with county transport for an appointment with the pulmonologist (lung doctor). Record review of nursing progress note dated 2/19/2025 at 4:15 PM written by the ADON indicated the facility was notified at 1:16 PM by the transport company that Resident #1 had got off the transport van and the transporter was unable to find Resident #1. At 1:45 PM Resident #1 was located and brought back to the facility. The ADON performed a head-to-toe assessment with no injuries noted. During an interview on 3/18/2025 at 9:15 AM LVN A said around lunch time on 2/19/2025 the DON came in to the secured unit and said to have Resident #1 ready to go at the door for his doctor's appointment. She said she took Resident #1 to the nurse's station. The Transport Driver came in and asked if this was Resident #1, she said yes, and the Transport Driver took Resident #1 out to the van. She said there was no report off to the Transport Drivers other than if they were transported via wheelchair or stretcher but that's the extent of it. She said the Transport Driver would not have known that day that Resident #1 was a resident of the secured unit. She said they send paperwork that included face sheet, medications, progress notes, and radiology with the Transport Driver but that paperwork was to be given to the doctor that the resident was going to see. She said there was no communication to the Transport Driver that Resident #1 was a resident of the secured unit. During an interview on 3/18/2025 at 11:00 AM the Administrator said Resident #1 was in the care of the county transport services and there was not anything different that his staff could have done to prevent Resident #1 from eloping from the van. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/18/2025 at 2:25 PM the Transport Driver said she went to pick up Resident #1 from the facility and called ahead to have Resident #1 ready. She said when she arrived, she asked LVN A where Resident #1 was, and LVN A pointed to Resident #1 standing at the nurse's station. LVN A walked off and did not give her any information about Resident #1. She said she had no knowledge of the Resident #1 residing on the memory care unit. She said she took Resident #1 and got him loaded in the van and went back in the facility to get another resident that was going to dialysis. She said she loaded the second resident and left the facility. She said she took Resident #1 to meet his sister at the pulmonologist office. The Transport Driver said after the appointment, Resident #1's sister called her back and let her know Resident #1 was ready to be picked up and taken back to the facility. The Transport Driver said she received a message while in route to pick up Resident #1 to pick up another resident at the hospital that needed to go back to the facility also. She said after she picked up Resident #1, she drove across the street to the hospital and parked at the front of the hospital. She said she was parked where the receptionist was able to visualize the van. She said she did not tell the receptionist that there was a resident in the van. She said as far as she knew Resident #1 was able to be left unattended. She said the van was left on to run the air conditioning. She said she was upstairs approximately 10 minutes to retrieve the other resident and when she returned to the van Resident #1 was gone. She said while she was assisting the new resident into the van, the receptionist came out to ask her to move the van to not block the driveway. She said she asked the receptionist if she saw Resident #1 exit the van and the receptionist said she did see the door open but did not see Resident #1 get out of the van. She said another nurse standing there called security to help locate Resident #1. She said the nurse, receptionist, and security started looking for Resident #1 and she called the shift leader over the transportation department. She said the shift leader said she was on her way and then called back to tell her that Resident #1 was a dementia patient. She said the shift leader spoke with staff at the facility and was informed Resident #1 resided on the memory care unit. She said she asked the receptionist if they could pull cameras to see which way Resident #1 went but she said that would be for security to do. She said the shift leader arrived and she was instructed to go ahead and take the other resident to the facility, so she left the hospital. She said when she got to the facility LVN A apologized for not telling her Resident #1 was a memory care resident prior to the appointment because these people are getting on my nerves and said she was sorry she was not used to having to tell the facility van drivers. She said after she dropped off the other resident at the facility and got back in the van, she called the shift leader who notified her that Resident #1 had been found. She said by this time Resident #1 had been missing for about 45 minutes to an hour. She said Resident #1 was found at a grocery store parking lot with a civilian who had given him a ride and realized something wasn't right and had called the police. She said the facility did not give them a history of what was going on with the residents when they transport. She said the facility knew they must send sitters with them for residents who have dementia or behavior problems. She said when they transport residents, they assume they were capable of taking care of themselves unless they were told otherwise. She said she would have had to have a sitter go with her had she known Resident #1 had dementia. She said she had transported for the facility since the incident and said she has started asking if the resident needs a sitter. She said since the incident her company did not leave any resident in the vehicle alone anymore. She said the facility had not changed their policy since the incident and just hands them the paperwork and says the resident was ready. She said she felt like there needed to be better communication. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/19/2025 at 11:32 AM the ADON said she was coming out of a resident's room, and someone came and told her the Transport Driver couldn't find Resident #1. She said her and the Administrator took the facility van and went looking for Resident #1. She said she talked to the shift leader and asked her what happened. She said the Transport Driver went into the hospital to get another resident and came back to the van and Resident #1 was gone. She said she asked which way he went but she didn't know. She said the shift leader called her back and said Resident #1 was at a grocery store parking lot. The ADON said the shift leader called her back to let her know the police had Resident #1 and were bringing him back to the facility. She said when they got back to the facility, she went and did a head-to-toe assessment on Resident #1 and the Administrator talked with the police officer. She said she did not find any injuries on his head-to-toe assessment. During an interview on 3/19/2025 at 12:05 PM the Admissions Coordinator said normally the facility transport driver sets up appointments for residents but she was helping out due to not having a facility transport driver until a new one could be hired. She said she set up the transport appointment for Resident #1. She said the facility and transport company have a text thread and she sent the appointment date, time, and resident's name. She said she usually texted if family will attend or if the resident needs a sitter. She said not all residents have to have a sitter or family, it was only required if the resident has a special need such as a fall risk or dementia. She said no information was sent to the transportation company about the resident prior to the appointment day. She said they make a folder with a face sheet, orders, progress notes, and telephone orders, and anything pertinent the doctor may need, and the transporters pick it up with the resident on the day of the appointment. She said the transport company had transported Resident #1 prior to this appointment and his sister had always met him at his appointments. She said if she had a sitter going or family would meet the resident, she would send that when setting up the appointment. They did not fax over any kind of information on the resident at the time the appointment was made. During an interview on 3/19/2025 at 12:27 PM the DON said a transporter came to the facility the morning of 2/19/2025 due to confusion about the appointment time for Resident #1. She said the transporter said he would send someone back to the facility at the right appointment time for Resident #1. She said the first transporter knew Resident #1 resided on the secure unit and would relay to the Transport Driver that information. She said she told LVN A to have Resident #1 ready and up front for his appointment. The DON said she never saw the Transport Driver when she came to pick up Resident #1 for his appointment. She said the next thing she knew was Resident #1's sister came back to the facility and brought Resident #1 a shake and fries and was waiting on him to get back from his appointment. She said she received a call from the Administrator that a police officer was bringing Resident #1 back to the facility and to have the officer wait until the Administrator got back to the facility. She said they did not in-service staff at the facility because the facility did not do anything wrong. She said Resident #1 went missing while in the care of the Transport Driver. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/19/2025 at 12:47 PM the Administrator said he got a call from the transport company that said Resident #1 was left in the van and was gone. He said he and the ADON left in the facility van to head to the hospital to help look for Resident #1. He said the business office manager took his vehicle to go look for Resident #1. He said he got a call from the transport company stating the police had Resident #1 and would be bringing him back to the facility. He said the police officer told him someone had picked him up 2 blocks away and realized he was confused. They pulled over at the grocery store parking lot and called the police to come get him. He said Resident #1 was returned to the facility with no injuries. He said the transport company was lucky Resident #1 did not drive the van through the hospital by leaving him unattended in the van. He said he expected the transport drivers to keep the facility residents under supervision at all times. He said he did not in-service his staff because they did not do anything wrong. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a statement dated 2/20/2025 at 8:28 AM written by the Transport Driver indicated: To whom it may concern, on Wednesday February 19,2025, I [Transport Driver] arrived at [facility], for patient pick up after calling ahead. For this particular trip transport included 2 patients [Resident #1 and another resident]. Upon entering the nursing I approached the patients nurse, [LVN A]. I spoke with [LVN A] briefly asking if the patient was ready. [LVN A] turned and pointed at a man standing at the nurses station and stated that's him [Resident #1] responded with a hello as I spoke hello to him first. I then turned and asked [LVN A] was [other resident] ready for transport. [LVN A] stated that she was not the nurse for [other resident] and proceeded to call down the 300 hall for [LVN B] as this was the patients nurse. [LVN B] made her way to the nurses station and told me that [other resident] was ready and that she would go get her. I turned to [Resident #1] and placed my hand on his arm and asked him to follow me, as I escorted him to the transport van. Originally [Resident #1] was listed as a wheelchair patient, bet he was not in a wheelchair. I assisted [Resident #1] as he sat in the back seat on the passenger side. I buckled [Resident #1] seatbelt and told him that I would return shortly, I needed to go get the other rider. [Resident #1] responded Ok I went back inside. I pushed [other resident] out of the nursing home. After [other resident] had been safely secured to the transportation van with all floor belts and seat belt intact I began transport. [Dialysis] was the first stop along the way. Seat belt and floor buckles were released and [other resident] was removed from the vehicle and moved inside of the Dialysis center. [Resident #1] remained inside of the vehicle. With continued transport, [Resident #1]and I arrived at [pulmonologist] office where [Resident #1's] sister awaited. I put the van in park and stepped out of the van to assist [Resident #1] with his exit. [Resident #1's] sister asked if he came with a coat as he attempted to leave the vehicle without it. I turned to retrieve the black coat for [Resident #1] as it had fallen to the floor. I passed the sticky note that I had previously written pick up information on to [sister]. [Resident #1] and I parted ways and that was the end of that trip. At approximately 2:17pm [sister] called giving notice that [Resident #1] was ready for pick up. In the process of responding to the pick up call, I received a message in the work group chat with a pick up request from [hospital], for a person going to [facility]. Upon arrival to the doctor's office [Resident #1] and his sister walked out to the transportation van and I again got out to assist [Resident #1] with entering the vehicle. [Sister] told him that she would meet him back at the nursing home with food. I made the decision to double load these patients as they were both going to the same location. I set out directly across the street to the hospital. Before exiting the vehicle I turned to [Resident #1] and stated that I had to go up to retrieve (pick up) someone that would be riding with us to [facility]. [Resident #1] responded by saying Ok. After 15 minutes I returned to the vehicle to load the rider. I immediately noticed that [Resident #1] was missing. I properly secured the new passenger and moved the van as the desk clerk inside the hospital came out and asked me to pull forward. I then proceeded to look for [Resident #1] I called lead person to notify her that [Resident #1] was missing. [Lead person] responded by saying I'm on my way I went back into the hospital to the information desk and spoke with the clerk. I asked her if she saw a man exit the vehicle. The clerk stated that she saw the door open but did not pay any attention to who may have entered or exited the vehicle. The male nurse standing by suggested that we call security and have them drive around. [Lead Person] (who had arrived at this time) stated that she notified the nursing home and that they told her that [Resident #1] is a memory care/dementia patient. The male nurse, myself, and [Lead Person] proceeded to check the hospital grounds for [Resident #1]. [Lead Person] stated that she would head over to administration to notify [administration]. I also requested that we pull cameras to see if we could determine which way [Resident #1] went. With the other passenger loaded [Lead Person] advised me to go ahead and deliver her to [facility]. [Lead Person] later messed the work group chat to notify the group that [Resident #1] had been found at [grocery store] and was currently in the care of [Local Police] department. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of police report dated 2/19/2025 at 1:33 PM indicated the police officer picked up Resident #1 from the grocery store parking lot and transported Resident #1 back to the facility at 1:43 PM. Record review of the facility incident report logs dated 1/1/2025 through 3/17/2025 indicated no incident report was completed for Resident #1's elopement. Record review of Transportation Services Agreement dated July 1, 2022, indicated in Exhibit A Transportation Services and Terms of Service: If the planned trip exceeds 25 miles one way, the Facility must provide a staff member to ride along with the patient and/or resident. Record review of the facilities Transportation, Diagnostic Services revised December 2008 indicated: Our facility will assist residents in arranging transportation to/from diagnostic appointments when necessary.3. Should it become necessary for the facility to provide transportation, the Social Service Designee will be responsible for arranging the transportation through the business office. 4. A member of the Nursing Staff, or Social Services, will accompany the resident to the diagnostic center when the resident's family is not available . https://weather. com/weather/monthly/l/Nacogdoches+TX?canonicalCityId=6947fed4fd766518bf7b5b8df4b57576 Accessed 3/26/2025 Nacogdoches, Texas weather on 2/19/2025 at 11:30 AM was cloudy and 37 degrees Fahrenheit. An IJ was identified on 3/18/2025. The IJ template was provided to the facility on [DATE] at 12:45 PM. While the IJ was removed on 3/19/2025, the facility remained out of compliance at a scope of isolated and a severity level of actual harm because all staff had not been trained on the transportation policy. The facility Administrator, and the DON were notified, and a plan of removal was requested. The facility's plan of removal was accepted on 3/18/2025 at 7:55 p.m. and included: What corrective actions have been implemented for the identified residents? A. On 3/18/2025 resident CR#1 involved in alleged deficient practice was assessed by the Director of Nursing and no changes noted in his baseline. B. On 3/18/2025 at 2:00 pm the Administrator notified, Medical Director of alleged deficient practice. C. The Corporate Clinical Service Director reviewed the Transportation Policy on 03/18/2025 at 6:48 pm and made an addendum noting, Residents on the secure unit will be transported by facility staff via facility van for appointments and they will require continuous supervision due to their disease process and the risk of elopement. How were other residents at risk to be affected by this deficient practice identified? A. All residents have the potential to be affected by the alleged deficient practice. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	What does the facility need to change immediately to keep residents safe and ensure it does not happen again? A. An in-service was initiated on 3/18/2025 by the facility administrator with nursing staff that residents on the secure unit will be transported by facility staff via facility van for appointments and they will require continuous supervision due to their disease process and the risk of elopement. The completion date is 3/19/2025 by 2:00 pm. B. Nursing staff will not be allowed to return to work until they receive this in-service. Nursing staff who are unable to physically attend the in-service training in person will be in-serviced via phone. The completion date is 3/19/2025 by 2:00 pm. C. Newly hired nursing staff will be in-serviced by the Director of Nursing or designee that residents on the secure unit will be transported by facility staff via facility van for appointments and they will require continuous supervision due to their disease process and the risk of elopement during facility orientation upon hire. Quality Assurance An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 3/18/2025 with the Medical Director. The Medical Director has reviewed and agrees with this plan. On 3/19/2025 the State Surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Record review of the electronic medical record indicated the DON conducted a head-to-toe assessment of Resident #1 with no changes noted in his baseline. Record review of facilities Transportation, Diagnostic Services policy updated on 3/18/2025 to include addendum: .7. [Facility] only. Residents on the secure unit will be transported by facility staff via facility van for appointments and they will require continuous supervision due to their disease process and the risk of elopement. Record review of in-service dated 3/18/2025 titled Transportation of Residents on Secure Unit signed by 106 facility employees. Record review of off cycle AdHoc QAPI meeting held on 3/18/2025 with the Medical Director, the Administrator, the DON, the ADON, the MDS, the Admissions Coordinator, the DOR, and Social Services were in attendance. During interviews on 3/19/2025 between 11:49 AM and 3:02 PM the following staff members across all shifts were able to verbalize understanding that residents on the secure unit would be transported by facility staff via facility van for appointments and they would require continuous supervision due to their disease process and the risk of elopement: DON, ADON, Admissions Coordinator, LVN B, LVN C, LVN D, LVN E, RN F, LVN G, LVN H, LVN J, LVN K, LVN L, LVN M, LVN N, RN O, and LVN P. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/19/2025 at 3:00 PM, the Administrator, and the DON were notified the IJ was removed. However, the facility remained out of compliance at a level of no actual harm with the potential for more than minimal harm with a scope identified as isolated due to the facility's need to monitor the implementation and effectiveness of its plan of removal.