

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 05/28/2025
NAME OF PROVIDER OR SUPPLIER Willowbrook Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assures the accurate acquiring, receiving, dispensing, and administering of medications for 2 of 6 residents (Resident #1 and #2) reviewed for pharmacy services.</p> <p>The facility did not ensure medications were stored properly for Resident #1 and #2. Medication was left on bedside table and Residents #1 and #2 are not care planned to have medication at bedside or to self-administer medications. Residents #1 and #2 does not have a physician order to have medication at bed side or to self-administer .</p> <p>These failures could place residents at risk for the unsafe administration of medications, not receiving prescribed doses of ordered medications and not receiving the intended therapeutic benefit of the medications.</p> <p>Findings included:</p> <p>Record review of facility face sheet dated 03/27/2025 indicated Resident # 1 were an [AGE] year-old female admitted to facility on 12/01/2021 with diagnosis of Unspecified Dementia, Cognitive Communication Deficit Functional Quadriplegia, and Metabolic Encephalopathy.</p> <p>Record Review of comprehensive care plan dated 05/27/2025 did not indicate Resident # 1 could keep medication at bed side or safely self-administer medications. The care plan reflects to administer medications as ordered.</p> <p>Record review of admission MDS dated [DATE] indicated Resident # 1 had a BIMS of 09 indicating moderate cognitive impairment.</p> <p>Record review of consolidated physician orders dated 05/27/2025 indicated Resident #1 had an order for Aspirin 81mg, Calcium Carbonate 750mg and ferrous gluconate 324mg which was observed in residents' room on her nightstand.</p> <p>During an observation and interview on 05/27/2025 at 10:39 am Resident # 1 was observed with medication on her nightstand. She stated she self-administer the medication occasionally and was confused if she took her morning medication or not. She said if the medications are still sitting there, she must have forgot to take them.</p> <p>(continued on next page)</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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility face sheet dated 03/27/2025 indicated Resident # 2 were a [AGE] year-old female admitted to facility on 03/31/2025 with diagnosis of Dementia, Bipolar Disorder and Urinary Tract Infection.</p> <p>Record Review of comprehensive care plan dated 05/19/2025 the care plan did not indicate Resident # 2 could keep medication at bed side or safely self-administer medications. The care plan reflects staff to administer medications as ordered by the physician.</p> <p>Record review of admission MDS dated [DATE] indicated Resident # 2 had a BIMS of 10 indicating moderate cognitive impairment.</p> <p>Record review of consolidated physician orders dated 05/27/2025 indicated Resident #2 did not have an order for CareALL Muscle and Joint Cream that was located in the resident's room on her nightstand.</p> <p>During an observation and interview on 05/27/2025 at 10:39 am Resident # 2 was observed with medication (CareALL Muscle and Joint Cream) on her nightstand. Resident #2 stated she self-administer the medication in the morning and at night. Resident #2 said she thought the facility provided it but was unsure who brought the medication to her.</p> <p>During an interview with LVN A on 5/27/2025 at 10:53am , who said no medication should be left in a resident's room unattended at any time. She said if the resident does not take the medication, they are not getting the proper effects of the mediation. She said another resident could accidentally ingest the medication and have an adverse reaction that could be deadly. She said all medications must be administered by a nurse or a mediation aide. LVN A said all residents should have a physician's order for any mediation administered to a resident. take.</p> <p>During an interview on 5/27/2025 at 11:52am with AR who said she has witnessed two to three times her family member's (Resident #2) medication in a cup at her bedside and not taken. She said Resident #2 has dementia and feels she's ok and that she gets all the medications she needs. AR said Resident #2's evening medications were being passed and her morning medications were still in a cup in the room and never administer to Resident #2. AR said she took the medication to the administrator who said she would handle it but when it happened again, AR let the administrator know she was calling the abuse hotline and report the abuse. AR said she just wanted to make sure Resident #2 as well as other residents get their prescribed medications as they should.</p> <p>During an interview on 5/27/2025 at 2:39pm with LVN-B who said she has never found medications left in a patient's room but have had medication in a resident's room (Resident #2) reported to her . She said all medications should be given timely and the resident should be monitored/assisted when taking mediation. She said if the resident does not take the medication at appropriate times, it could cause a negative effect. She said a resident could take medications to close to the next dose or a resident may miss a dose all together. LVN B said another resident may wonder into the room and take the medication and cause a negative effect on them as well.</p> <p>During an interview on 5/28/2025 at 3:05pm with CNA-C, who said all medications must be given by a nurse or the medication aide. She said all residents need to get their medications as prescribe daily. She said if medications are given or taken wrong the resident could have a greater chance to get sick.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 5/28/2025 at 1:58pm with CNA-D, who said she has not witnessed anyone having medication left in their room. She said another resident could get the medication, take the medication, and get sick. She said the resident may take the medication at the wrong time. She said If the medications are not taken correctly the residents may become sick.</p> <p>During an interview on 5/28/2025 at 2:07pm DON, who said she never witness medication at bedside but medications at bed side have been reported to her in the past. She said no residents in the facility should have medication at their bedside. She said no residents are care planned to have medications in their rooms. She said all medications administered should have a physician's order and be administered by a nurse or medication aide. She said if a resident does not get medication as prescribed, they are not getting the intended therapeutic outcome of the medications. She said the residents could get their does too close together or not at all causing the residents to have a negative outcome. She said another resident could come in the room and get the medication which could cause that resident to become ill. DON said if a resident takes medications at the wrong time or take the wrong medication it could be detrimental to the resident.</p> <p>During an interview on 5/29/2025 AT 2:27pm with the administrator who said he was not aware of any residents having medications left in their room. He said no residents in the facility are care planned or have orders to have medications in their room and all medications should be removed immediately if not taken by the resident during the attempt to administer the medication. He said a nurse or medication aide must administer any prescribed medication. He said each resident must have a physician's order for all medications administered to any resident admitted to the facility. He said not taking medications as ordered could cause negative effects by altering the effects of the prescribed medications, causing labs and levels to be off and putting other residents in the facility at risk of unnecessary medication intake. He said another resident could wonder into the room and get the medication, take it, and cause harm to themselves.</p> <p>Record Review of Inservice Training dated May 22, 2025, topics: Medication Administration indicated, Meds should never be set up in advance, or left at the beside for a resident to take. Meds will not be left at bedside for any reason. If refused take meds out and notify the charge nurse.</p> <p>Record Review of Administering Medications Policy (revised December 2012) indicated, All medications shall be administered in a safe and timely manner, and as prescribed. 1. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so.</p> <p>24.Residents may self-administer their own medications only if the Attending Physician and Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.</p> <p>Record Review of Storage of Medication Police, (revised April 2007) indicated, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.</p>		