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	07/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 3 of 15 residents (Residents #13, #56, and #2) reviewed for resident rights. 1. The facility failed to ensure Resident # 13, and Resident #56 were served breakfast in the dining room in a dignified manner on 7/08/2025.2. The facility failed to ensure CNA K did not stand over Resident # 2 while feeding her on 7/7/25. This failure could place residents at risk for decreased quality of life, quality of care, and self-esteem. Findings included:1.Record review of a facility face sheet dated 7/09/2025 revealed Resident #13 was a [AGE] year old female that admitted to the facility on [DATE] for diagnosis of hypertensive heart disease (heart condition caused by high blood pressure).Record review of Resident #13's admission MDS assessment dated [DATE] revealed Resident #13 had a BIMS of 02 indicating severely impaired cognition and required assistance and setup for eating.Record review of resident #13's comprehensive care plan dated 6/26/2025 revealed Resident #13 had an ADL Self Care Performance Deficit and required total assist from staff in participation for eating.Record review of a facility face sheet dated 7/09/2025 revealed Resident #56 was a [AGE] year old female that admitted to the facility on [DATE] with hemiplegia following cerebral infarction (paralysis after a stroke).Record review of Resident #56's Quarterly MDS assessment dated [DATE] revealed Resident #56 had a BIMS of 10 indicating moderately impaired cognition and required setup assistance for eating.Record review of Resident #56's comprehensive care plan dated 6/18/2025 revealed Resident #56 had an ADL Self Care Performance Deficit related to hemiplegia from a stroke and required staff to setup meals for eating.During an observation on 7/08/2025 at 8:05 am Resident # 13 and Resident # 56 was not served breakfast with the rest of their table. Resident #13 was touching the CNA B's shoulder and saying, I am ready. Resident #56 said she did not know where her breakfast was, and she was hungry. Both residents sat over 10 minutes without a meal tray before being served.During an interview on 7/08/2025 at 9:20 am CNA B said that she assists in the dining room with meals and the dietary staff had a list and knew which residents ate in the dining room and which ones ate in their rooms. She said there was also a nurse that oversaw the meal trays. She said she was assisting another resident and Resident #13 was next to her. She said Resident #13's tray did not get served with the others at the table, so she proceeded with feeding the other resident. She said Resident #13 was tapping her and saying I am ready, and she should have gotten up and went and gotten her tray, but she just waited for it. She said that residents that aren't feed together at the table could make them upset and feel bad. During an interview on 7/08/2025 at 9:25 am LVN C said he was the nurse in the dining room this morning and he did not notice Resident #13, and Resident #56 did not get served with the others. He said Resident #56 feeds herself and Resident #13 needed assistance. He said when he noticed he went and asked about their trays. He said he did not know how long they had sat without getting served before he noticed. He said that residents in the dining room should be served at the same time per each table and by not doing so the residents could feel overlooked or not cared about. During an interview on 7/08/2025 at 2:00pm the DON said that all staff had been trained on dignity and how to pass trays appropriately. She said the nurses and aides were in the dining room to observe and assist as well as making sure each resident was served together at the table. She said that a resident that must sit and watch other residents eat could make them feel overlooked. She said the administrator is out but expected the facility to treat all residents with dignity and serve meals per the policy. 2. Record review of a facility face sheet dated 7 /9/25 for Resident #2 indicated that she was an [AGE] year old female admitted to the facility on [DATE] with diagnoses of dysphagia (difficulty swallowing), hypertension (high blood pressure), and dementia.Record review of a quarterly MDS assessment dated [DATE] for Resident #2 indicated she had a BIMS score of 8, which indicated moderately impaired cognition. She required maximal assistance with eating.Record review of a comprehensive care plan dated 5/20/25 for Resident #2 indicated she had impaired cognitive function/dementia and had an intervention to assist resident with meals and to provide the resident with a homelike environment.During an observation on 7/7/25 at 12:04 pm CNA K was observed standing over Resident #2 in her room while feeding her.During an interview on 7/8/25 at 11:01 am CNA K said she was unsure why standing over residents to feed them would be inappropriate. During an interview on 7/9/25 at 4:32 pm ADON said standing over residents while feeding them was a dignity issue as it could make them feel bad.During an interview on 7/9/25 at 4:54 pm Clinical

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident status for 1 of 8 residents (Resident #66) reviewed for MDS assessment accuracy, in that:Resident #66's MDS quarterly assessment dated [DATE] failed to indicate Resident #66 had a physical or verbal behaviors directed or not directed toward others.This failure could place residents at risk of not receiving adequate care and services to meet their needs.Findings included:Record review of a facility face sheet dated 7/9/25 for Resident #66 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of dementia, personality change, and hypertension (high blood pressure).Record review of a quarterly MDS assessment dated [DATE] for Resident #66 indicated a BIMS score of 12, indicating moderately impaired cognition. Section E (Behavioral Symptoms) indicated no physical or verbal behavioral symptoms or other behavioral symptoms (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) directed or not directed toward others. MDS indicated an Assessment Reference Date of 6/13/25 and indicated .look back period for all items is 7 days unless another time frame is indicated . Section E did not indicate another time frame for look back period.Record review of a behavior note dated 6/12/25 for Resident #66 read: . Behavior: Resident made inappropriate remarks to female med aide . and . Nonpharmacological Interventions: Resident was asked to stop and go back to his room . and . Results: Resident went back to his room and got back in bed . and was signed by LVN L.Record review of a behavior note dated 6/13/25 for Resident #66 read: . Behavior: Resident having inappropriate behavior with this nurse. I come back from break and went to use the bathroom. Resident followed this nurse and wait out at the bathroom door . and . Nonpharmacological Interventions: Resident was asked to be respectful and go back to his room . no results were documented and not was signed by LVN M.Record review of a comprehensive care plan dated 6/18/25 for Resident #66 indicated he may display inappropriate sexual behaviors with the following intervention: . Explain and explore with resident effects of his/her behavior on other residents and staff . During an interview on 7/9/25 at 4:29 pm MDS Coordinator said they do not have a specific MDS policy, they follow the RAI manual. She said the MDS assessment triggers the care plans, and some resident care may not be included in care plan if MDS was not completed accurately. During an interview on 7/9/25 at 4:32 pm the ADON said the DON was responsible for ensuring the MDS was completed accurately. She said if the MDS was not completed accurately, it could affect resident care. During an interview on 7/9/25 at 4:54 pm Clinical Services Director said behaviors should be captured in the MDS assessment because triggers go to care plan and there might not be a good reflection on what was going on with the resident. The DON and Administrator both were unavailable for interview on 7/9/25.Record review of RAI manual retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf read: .E0200: Behavioral Symptom-Presence & Frequency: .Coding Instructions: Code 0, behavior not exhibited: if the behavioral symptoms were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7 days. Code 1, behavior of this type occurred 1-3 days: if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days. Code 2, behavior of this type occurred 4-6 days, but less than daily: if the behavior was exhibited 4-6 of the last 7 days, regardless of the number or severity of episodes that occur on any of those days. Code 3, behavior of this type occurred daily: if the behavior was exhibited daily, regardless of the number or severity of episodes that occur on any of those days.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain personal hygiene for 2 of 8 residents (Residents #1 and #42) reviewed for ADL care. The facility failed to clean/groom Resident #1's fingernails that had a dark, brown substance underneath them on 7/7/25 and 7/8/25.The facility failed to trim/file Resident #42's fingernails that were long and jagged on 7/7/25 and 7/8/25.These failures could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs which could result in poor care. Findings included:Record review of a facility face sheet dated 7 /8/25 for Resident #1 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of cerebral infarction (stroke) and hypertension (high blood pressure).Record review of a quarterly MDS assessment dated [DATE] for Resident #1 indicated a BIMS score of 11, indicating moderately impaired cognition. He required substantial/maximal assistance with personal hygiene.Record review of a comprehensive care plan dated 6/17 /25 for Resident #1 indicated he had an ADL self-care performance deficit. There was no specific intervention for personal hygiene/nail care.Record review of a facility face sheet dated 7 /8/25 for Resident #42 indicated he was a [AGE] year-oldmale admitted to the facility on [DATE] with diagnoses of Parkinson's Disease (a movement disorderthat affects the nervous system and worsens over time) and peripheral vascular disease (a condition inwhich narrowed arteries reduce blood flow to the arms or legs.).Record review of a quarterly MDS assessment dated [DATE] for Resident #42 indicated he had a BIMSscore of 6, which indicated severely impaired cognition. He was dependent for personal hygiene.Record review of a comprehensive care plan dated 6/17/25 for Resident #42 indicated he had an ADLself-care performance deficit and had the following intervention: . The resident requires staffassistance with personal hygiene . During an observation and interview on 7/7/25 at 9:58 am Resident #1 was observed with fingernails on both hands long, jagged, and dirty. There was a brown substance caked under them. He said he would like to have them cleaned, trimmed and filed. He said it would make him feel better. During an observation and interview on 7/7/25 at 10:12 am Resident #42 was observed lying in bed. His fingernails were observed to be long and jagged, in need of trimming and filing. He said he would like them to be trimmed.During an observation on 7/8/25 at 9:30 am Resident #1 was observed to still have the brown substance caked underneath his fingernails and nails were still long and jagged.During an observation on 7/8/25 at 9:33 am Resident #42 was observed to still have long, jagged fingernails. During an interview on 7/8/25 at 2:50 pm CNA M said CNAs were responsible for nail care on non-diabetic residents. She said if a resident was diabetic, the nurse was responsible for their nail care. She said she normally tried to do nail care during showers. She said she did not have either one of those residents today and was unsure why their nail care had not been done. During an interview on 7/9/25 at 4:32 pm the ADON said she expected staff to clean resident's nails during showers. She said residents could be at risk of scratches and infections if nails were allowed to stay long and dirty.During an interview on 7/9/25 at 4:54 pm Clinical Services Director said nails should be cleaned daily and trimmed/filed when needed. He said residents could be at risk of injury and infection.Record review of a facility policy titled Care of Fingernails/Toenails dated April 2007 read: . Thepurposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections . and .1. Nail care includes daily cleaning and regular trimming .

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 2 of 12 residents reviewed for quality of care, (Residents #43 and #58:The facility failed to remove worn and damaged mechanical lift slings from service for Resident's #43and #58.This failure could place residents at risk of injuries due to environmental hazards. Findings included:Record review of a facility face sheet dated 7 /8/25 for Resident #43 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Alzheimer's disease and type 2 diabetes. Record review of a quarterly MDS assessment dated [DATE] for Resident #43 indicated she wasrarely/never understood and was unable to complete BIMS assessment. She had severely impairedcognition. She was dependent for all ADLs, including transfers.Record review of a comprehensive care plan dated 6/17/25 for Resident #43 indicated she had an ADLself-care performance deficit and had the following intervention: . TRANSFER: The resident requirestotal assistance with transfers .Record review of a facility face sheet dated 7/8/25 for Resident #58 indicated he was a [AGE] year-oldmale admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (a disorder thatcan affect the brain and cause altered mental status) and Alzheimer's disease.Record review of a quarterly MDS assessment dated [DATE] for Resident #58 indicated he wasrarely/never understood and BIMS assessment could not be completed. He was severely cognitivelyimpaired. He was dependent for transfers and all other ADL's.Record review of a comprehensive care plan dated 6/17 /25 for Resident #58 indicated he had an ADLself-care performance deficit and had the following intervention: .TRANSFER: The resident requirestotal assistance with transfers .During an observation on 7/7/25 at 12:00 pm Resident #58 was observed in Geri-chair near nurses' station. He had a blue mesh sling underneath him. The labels on the sling were crinkled, faded, and unreadable. The first loop was observed to be very light pink in color and the other 2 loops were an extremely light gray, any color difference was indistinguishable. The edge of the black webbing also appeared to be fraying. During an observation on 7/9/25 at 9:33 am a sling was observed in Resident #43's wheelchair with faded loops and tag.During an interview on 7/9/25 at 9:45 am LVN C said when Resident #43 gets out of bed, she was transferred using a mechanical lift and the sling in the wheelchair was hers. He said he did not know about the sling and if it could be used with faded loops but could see how that could cause injury if the sling was in poor condition.During an interview on 7/9/25 at 4:22 pm Housekeeping Supervisor said he was responsible for laundering slings. He said they were not laundered with bleach, and they were only air dried, never placed in a dryer. He said he inspected the slings for discoloration, tears, strings and ensured labels were readable before sending back out for resident use. He said residents could have an accident if a bad sling was used. During an interview on 7/9/25 at 4:32 pm ADON said she was unsure if CNAs knew what to look for regarding the slings before, but she would ensure education was provided. She said residents could be at risk for harm if a malfunction occurred. During an interview on 7/9/25 at 4:51 pm Clinical Services Director said lift slings should be removed from service when labels were unreadable or if it showed other signs of wear and tear. He said it could pose a safety hazard and could result in a resident fall. Record review of manufacture guidelines Full Body Slings - Instructions for use accessed at www.medline.com on 07/09/25 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 .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food prepared in a form designed to meet individual needs for 1 of 4 (Residents #98) residents reviewed for food to meet nutritional needs. The facility failed to ensure Resident #98 was not served thin liquids on 7/07/2025 and 7/08/2025. This failure could place residents at risk of difficulty swallowing, possibly resulting in choking.Findings Included:Record review of a facility face sheet dated 7/08/2025 revealed Resident #98 was a [AGE] year old male that was admitted to the facility on [DATE] with diagnosis of senile degeneration of brain (mental decline due to age).Record review of Resident #98's admission MDS assessment dated [DATE] revealed Resident #98 had a BIMS of 3 indicating severely impaired cognition and had episodes of difficulty swallowing.Record review of Resident #98's comprehensive care plan dated 6/18/2025 revealed Resident #98 required nectar consistency liquids and to provide the diet as ordered by the physician. Record review of a physician order dated 6/23/2025 revealed Resident #98 required nectar thickened liquids . During an observation on 07/07/2025 at 10:40 am Resident # 98 had ready-made thickened water and a water pitcher with regular water on his bedside table. During an observation and interview on 7/08/2025 at 8:16 am Resident #98 had regular water in a pitcher next to his bed. A family member was present in room and said he needs thickened water now, but she does give him regular water at times and thought it was ok since it was in the room. She said he does have a hard time swallowing and would not give him regular water anymore. CNA D was in the room assisting Resident #98 with breakfast and removed the water from the room and said he was to get thickened water, so he did not get choked. During an interview on 7/08/2025 at 8:33 am the hospitality aide said she was responsible for passing fresh ice and water and there was not a visual aide to let her know he needed thickened water that she was given a report to know. She said she thought Resident #98 could have regular water and thickened water and a nurse told her that but not sure what nurse it was. She said she did not know it was bad for a resident that required thickened water to drink regular water but thinking about it know they could get choked.During an interview on 7/08/2025 at 8:45 am the DON said she did the trainings in the facility and the hospitality aide passed fresh ice and water and was given a report on who gets thickened water and who did not get a water pitcher. She said she had been trained to know and expected the hospitality aide to follow the orders . She said they did not use a visual assistant for the staff to know who required thickened liquids. She said residents that get regular liquids instead of thickened liquids could choke or aspirate. She said the administrator was out, but she expected each resident with prescribed thickened liquid diets to receive the ordered diet and not have thin liquids provided to them.Record review of a facility policy titled Therapeutic Diets dated November 2015 indicated, .therapeutic diets shall be prescribed by the attending physician; use an identification system to ensure that each resident receives ordered diet .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 4 residents (Resident #2, #20 and #16) and 4 of 5 staff (CNA A, CNA G, CNA K and CNA F) reviewed for infection control. 1. The facility failed to ensure CNA A properly changed gloves and cleaned her hands during incontinent care for Resident #20 on 7/08/2025.2. The facility failed to ensure CNA G performed hand hygiene between passing of resident #16's tray on hall 500 on 7/8/25.3. The facility failed to ensure CNA F removed soiled gloves and before hand hygiene before exiting Resident #16's room on 7/9/25.4. The facility failed to ensure CNA K performed hand hygiene between the passing of residents' meal trays and before feeding Resident #2 on 300 hall on 7/8/25.These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included: 1. Record review of a facility face sheet dated 7/08/2025 revealed Resident #20 was a [AGE] year-old female that admitted to the facility on [DATE] for metabolic encephalopathy (chemical imbalance in the blood that affects the brain). Record review of Resident #20’s Quarterly MDS assessment dated [DATE] revealed a BIMS was not completed. Further review revealed a staff assessment for mental status (SAMS) was completed and indicated severely impaired cognitive skills for daily decision-making, was dependent on staff for toileting hygiene, required indwelling catheter and was always incontinent of bowel. Record review of Resident #20’s comprehensive care plan dated 6/17/2025 revealed Resident #20 had an ADL Self Care Performance Deficit and was totally dependent on staff for toilet use. During an observation on 7/08/2025 at 10:15 am Resident # 20 was provided incontinent care by CNA A and CNA B. Both CNA's applied PPE for EBP and performed hand hygiene and applied gloves. CNA A positioned Resident #20 and opened her brief. CNA A used wipes to clean the front peri area and catheter. CNA B rolled Resident #20 to her left side and CNA A removed her soiled gloves and applied clean gloves without performing hand hygiene. CNA A then cleaned stool from Resident #20 using wipes and then removed the soiled brief. CNA A then using soiled gloves applied a clean brief and fastened it into place. CNA A then adjusted Resident #20's linens and pillows and bed with bed remote with same soiled gloves. Both CNA’s then removed their PPE and gloves and washed their hands before leaving the room. During an interview on 7/08/2025 at 10:25 am CNA A said she had been trained on incontinent care and infection control and had been checked off. She said she should have performed hand hygiene between glove changes and should have removed her soiled gloves and washed her hands before proceeding with applying any clean items or touching the resident's items. She said by not doing so increases the risk of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/08/2025 at 2:30 pm the DON said that she was responsible for the infection control program and that CNA A had been trained on infection control with incontinent care. She said she expected all staff to follow the facilities policy on infection control and by not doing so infections could spread. She said the administrator was out and she would oversee that infection control practices were followed. Record review of a CNA skills checklist and competencies dated 3/05/2025 revealed CNA A had met competency for infection control, handwashing, and peri care. 2. During an observation on 07/07/2025 beginning at 8:30AM, CNA G passed trays to all residents on hall 500 without sanitizing her hands between. CNA G was observed providing direct contact by touching the residents clothing, tables, and personal items on the table while in rooms and not sanitizing her hands when she left from resident to resident’s rooms. During an interview on 07/07/2025 at 1:30 PM, CNA G she said she should have sanitized her hands between passing each resident’s breakfast tray to prevent the spread of germ and bacteria. She said staff was trained on hand hygiene recently. She said she was nervous and just forgot and was trying to hurry and complete the task of passing the trays. During an interview on 07/09/2025 at 1:35 PM, CNA E she said staff should sanitize between passing each resident’s tray. She said staff should pull off gloves and wash hands prior to leaving a resident’s room after performing any type of direct patient care. She said if you leave the room with contaminated gloves on you will contaminate anything that you touch while wearing soiled gloves and prior to washing your hands. She said not all staff follow the correct protocols even though they have received training. 3.During an observation on 7/9/2025 at 12:30pm CNA F was observed leaving Resident 16’s room with her gloves on and going to the clean linen cart getting a clean gown. She returned to the room to finish care of resident #16 and proceeded to set resident #16’s tray up without removing or changing her gloves. . During an interview on 07/09/2025 at 1:42 PM, CNA F said during the care provided to Resident #16, she should have pulled off her gloves, washed her hand and or used sanitizer prior to leaving out of resident 16’s room to retrieve her a clean gown. She said she just forgot and was trying to clean the resident up as fast as she could because another resident was needing incontinent care at the same time, and she needed to assist in passing the breakfast trays. She said residents could be at risk for infections. She said she had training and skills check off on hand hygiene in the past month. During an interview on 07/09/2025 at 4:32 PM, the ADON she said hands should be sanitized or washed before care was started of any kind on a resident, during care being provided as needed, after changing gloves, when going from dirty to clean, after care was completed and prior to leaving the resident’s room. She said she expect her staff to wash hands prior to changing task and going from one resident to the other to perform direct care. She said if hands are not correctly cleaned it opens the door for the spread of germs, infections, and illness to the residents. She said she would like to see staff use proper hand hygiene and infection control in the future. During an interview on 06/09/2025 at 4:50 PM, the corporate manager said when passing trays staff should perform hand hygiene prior to the start of passing trays and staff should perform hand hygiene between passing each resident’s tray. He said if good hand hygiene is not conducted properly the spread of infection increases. 4.Record review of a facility face sheet dated 7 /9/25 for Resident #2 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of dysphagia (difficulty swallowing), hypertension (high blood pressure), and dementia. (continued on next page)

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	07/09/2025

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a quarterly MDS assessment dated [DATE] for Resident #2 indicated she had a BIMS score of 8, which indicated moderately impaired cognition. She required maximal assistance with eating. Record review of a comprehensive care plan dated 5/20/25 for Resident #2 indicated she had impaired cognitive function/dementia and had an intervention to assist resident with meals and to provide the resident with a homelike environment. During an observation on 7/7/25 at 12:04 pm CNA K was observed to pass a tray to a resident room, raise the head of his bed and exit room without performing hand hygiene. She was then observed to pick up another tray, pass it to a resident in their room, raise the head of residents’ bed using the bed controller, removed lid from residents’ tray, add salt/pepper, pick up spoon and stir residents’ food, then exit room without performing hand hygiene. She then went to cart, picked up tray for Resident #2, entered Resident #2’s room, raised the head of her bed using bed controller, set up residents’ tray and begin feeding her without performing hand hygiene. During an interview on 7/8/25 at 11:01 am, CNA K said she had used hand sanitizer before starting to pass out the meal trays, but she did not use it or wash hands between the passing and setting up of trays or before starting to feed Resident #2. She said she could see that it could cause an infection control problem if she did not perform hand hygiene. During an interview on 7/9/25 at 4:32 pm ADON said staff should wash hands or use sanitizer when passing and setting up trays and should wash hands before feeding a resident. She said residents could be at risk of infections spreading if staff did not perform hand hygiene. During an interview on 7/9/25 at 4:54 pm Clinical Services Director said he expected his staff to wash hands or use sanitizer when passing trays and to wash hands before feeding a resident. He said it could put residents at risk of infections. Record review of a facility policy titled Perineal Care dated December 2011 indicated, .to prevent infections and skin irritation; 12. remove gloves and wash hands, 13. put on new gloves and place new brief, 14. reposition linens . Record review of a facility policy titled Handwashing/Hand Hygiene dated 2001(revised June 2010) indicated, .Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: All personnel shall be following the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: c. before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice)”. g. Before and after assisting a resident with meals . and . use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: . i. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident .