DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/01/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345466	B. WING			C 08/03/2020	
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK REHABILITATION AND CARE CENTER			1	STREET ADDRESS, CITY, STATE, 2 333 EAST LEE STREET YADKINVILLE, NC 27055	STREET ADDRESS, CITY, STATE, ZIP CODE 333 EAST LEE STREET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ON
F 000	was conducted on 8/2 allegations were unsularly affect the surve was issued a new Stareflected tag F-609 w	usite complaint investigation 2/20. 6 out of the 6 ubstantiated. and from the survey report of the formation provided by the by. On 08/17/20, the facility attement of Deficiencies that as deleted and no end as a result of this onsite	F	000	iENGT)		
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RF	TITLE		(X6) DATE	

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.

Electronically Signed

08/20/2020