Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLI	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		NH0559	B. WING		C 11/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
		619 LAU	REL LAKE DRIV		
WILLOWE	BROOKE COURT SC CTI	COLUME	SUS, NC 28722		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
L 000	INITIAL COMMENTS	3	L 000		
	was conducted from Event ID# 7X6S11. investigated: NC0020	nplaint investigation survey 11/18/24 through 11/20/24. The following intakes were 08598 and NC00215311. 2 of ations resulted in deficiency.			
L 049	.2210(A) REPORTIN ABUSE, NEGLECT	G, INVESTIGATING	L 049		12/17/24
	to prevent patient ab misappropriation of p orientation and instru patients' rights and th	facility shall take measures use, patient neglect, or eatient property, including oction of facility staff on the screening of and ces for all prospective			
Division of Ho	Medical Director, res the facility failed to pu utilizing a resident's p personal gain (Resid protect residents' righ misappropriation of c (Resident #63, Resid for 4 of 4 residents re of resident property.	ns, record review, and ident and staff interviews, revent an employee from personal finances for ent # 65) and failed to		Upon notification of the two missing of cards, investigation started immediate Initial allegation (24 hour) report sent the Healthcare Personnel Registry (9/29/2023), Polk County Sheriff□s Department contacted and deputy on campus to file report (9/29/2023). On 9/29/2023, audit conducted of aler and oriented residents residing on assisted living. Audit included compla of missing items and feeling of securit Audit conducted by the administrator at the sheriff□s deputy.	t ints

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE 12/09/24

Electronically Signed

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER	EK.	A. BUILDING: _		COMPLETED	
				B. WING		С	
		NH0559		D. WING		11/20/2024	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WILL OWB	ROOKE COURT SC CTR	R AT TRYON ESTATE	619 LAURE	L LAKE DRIV	E		
			COLUMBU	S, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	ETE
L 049	Continued From page	e 1		L 049			
	07/13/22.						
	A Resident Status and Nursing Assessment Resident #65 was ale Review of the facility's 10/04/23 revealed on aware of an allegation property for Resident was initiated. The represident #65 reported cards were missing fround did not report it be misplaced them. "[Resident #65 reported cards were missing fround did not report it be misplaced them. "[Resident #65 reported cards were missing fround the cards in the dress them out and placed them out and placed the recliner to take to the next morning, should have also the card statements."	s investigation report da 09/29/23 the facility be n of misappropriation of #65 and an investigatio	d d d d d d d d d d d d d d d d d d d		Education on policy of misappropriation resident sproperty started on 9/29/21 for staff on assisted living by the nursing home administrator (NHA) and director assisted living (DAL). Education was completed on 10/20/2023. This education is also conducted annually and on him Re-education on the policy of misappropriation of resident property conducted for staff on assisted living. Re-education will be provided by the nursing home administrator and completed by 12/17/2024. Staff will not allowed to work after this date until education is completed. Education is received upon hire, annually and as needed. Residents on assisted living will be not of the availability of lock boxes, at the	ng r of tion e. o be also	
		charged on each card." ccused employee was de (NA) #1.	The		request, during the next resident cour meeting on 12/12/2024.		
	A review of NA #1's e had been screened b she completed trainin neglect and exploitati	mployee file revealed sl efore hire and on upon g modules on abuse, on.	hire,		Audits will be conducted with three ale and oriented residents, to include interviews asking about missing items misappropriation. Audits will occur thr times weekly for two weeks, then wee for 4 weeks, then randomly and conduby the NHA and DAL. Results from the	and ee kly icted	
	PM, NA #1 confirmed cards from Resident # Resident #65's conset totaling approximately asked why she had to cards without her contime, she was off her	terview on 11/18/24 at 2 she had taken two cred #65's room, without ent, and made purchase \$\text{y}\$500 on each card. Waken Resident #65's cresent, NA #1 stated at the medication and was has che caused her to not thir	dit s /hen dit ne ving		audits will be presented at the Januar 2025 and April 2025 quality assurance meetings. Completion date 12/17/2024	/	

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STATE FORM 6899 7X6S11 If continuation sheet 2 of 33

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
					С
		NH0559	B. WING		11/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	
			REL LAKE DRIV		
WILLOWE	BROOKE COURT SC CTR	R AT TRYON ESTATE	BUS, NC 28722	_	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETE
L 049	Continued From page	2	L 049		
	clearly or make good	decisions.			
	AM, the Law Enforcer spoke with NA #1 and the two credit cards from consent and making parts with a combine stated NA #1 never go took the credit cards the did. He stated chiled, warrants for arreturned herself in to late				
	the Director of Nursin revealed she received 09/29/23 regarding R credit cards were mis investigation was initi recalled Resident #65 time she had seen the had taken them out of	n 11/19/24 at 2:34 PM with g present, the Administrator d a grievance report on esident #65 reporting two sing from her room and an ated. The Administrator 5 could not recall the last e credit cards only that she f the drawer where they			
	then the appointment forgot about the credi stated Resident #65 c cards were missing a misplaced them until the credit card statem had been made on be approximately one me reporting them missin Administrator stated c investigation was ong came to her office and two credit cards without the cards without the credit cards	her to an appointment but was cancelled and she t cards. The Administrator did not realize the credit not thought she had just her family member received nents and noticed charges of the cards at a retail store onth prior (08/2023) to her on 10/02/23 while the facility joing, NA #1 voluntarily d confessed to taking the out Resident #65's consent reason why. She stated NA			
	#1 was immediately s Administrator stated b				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	, , ,	E SURVEY PLETED
		NH0559	B. WING		11	C 1/ 20/2024
	ROVIDER OR SUPPLIER	619 I	ET ADDRESS, CITY, STAT LAUREL LAKE DRIVE UMBUS, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 049	confession, the allegate property was substant employment was office 10/04/23. 2. The facility's Abuse Misappropriation of Revised on July 31, 20 facility would safeguate from any form of abust their property. Resident #63 was ad 09/18/23 with diagnost and fibromyalgia. She 04/12/24. A review of the physic revealed Resident #60.5 milliliters (ml) of limilligrams (mg)/5 ml meeded for pain or she of the pharm 03/21/24 coded Resident would be of liquid morphanalgesic for the relies acute and chronic paracontained 15 ml in earthese 2 bottles of liquid received and signed of the medication admirevealed Resident #60. The medication admirevealed Resident #60.	ation of misappropriation of stiated and NA #1's cially terminated on e., Neglect, or resident property policy, last 023, revealed in part the ard and protect all residents se or misappropriation of mitted to the facility on ses including low back pain expired in the facility on expired in the facility on once expired in the facility on once every 1 hour as nort of breath. Im Data Set (MDS) dated dent #63 with an intact macy delivery receipt dated expharmacy had delivered 2 hine sulfate (an opioid of of moderate to severe in) 100 mg/5 ml that arch bottle for Resident #63. uid morphine sulfate were by Nurse #6.	L 049			
	I	te 2 times as needed on 4. and 3 times as needed on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		71. 501251110.		C
	NH0559	B. WING		11/20/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WILLOWBROOKE COURT SC	TR AT TRYON ESTATE	EL LAKE DRIV US, NC 28722	E	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
received any morp A review of the state Nurse #2, Nurse #7 had access from the following the sulfate from the following the sulfate from the following the sulfate from the following t	R did not indicate she had hine on 03/30/24. ffing roster and MARs revealed 3, Nurse #4, Nurse #6, and less to Resident #63's liquid om 03/27/24 through 03/30/24 imelines: O PM, Nurse #6 signed and hacy delivery including 2 bottles sulfate. She passed the 2 rephine sulfate to Nurse #7 O PM, Nurse #6 conducted a tic count with Nurse #7 before dication cart. OO PM to 03/28/24 7:00 AM - less to the medication cart. OO AM to 11:00 PM, Nurse #3 medication cart. OO AM to 3:00 PM, Nurse #3 medication cart. OO AM to 3:00 PM, Nurse #3 medication cart.	L 049		

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. `	•	CONSTRUCTION	(X3) DATE SI COMPLE	
				_		c	
		NH0559	В	8. WING		1	0/2024
NAME OF P	ROVIDER OR SUPPLIER	S	TREET ADDRES	SS CITY STAT	TE ZIR CODE		
TVAINE OF T	NOVIDEN ON GOLT EIEN		19 LAUREL I	, ,	,		
WILLOWE	BROOKE COURT SC CTR	R AT TRYON ESTATE	OLUMBUS, I		-		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
L 049	Continued From page	÷ 5	L	L 049			
	Resident #63 contain	ing 15 ml was noted to be					
		hange narcotic count.					
	Resident #63 had and						
	morphine sulfate for u						
	occurred. Investigatio						
		OON) immediately. The					
	, ,) and Resident #63 were					
	notified of the inciden	1 011 03/30/24.					
	The 5-day investigation	on report dated 04/02/24					
	revealed once the DC	N was notified of narcotic	;				
	count discrepancies r	elated to Resident #63's					
		e, she conducted narcotic					
		ne controlled medications	in				
	_	ly without identifying any					
		ies. The DON interviewed					
		om the time of receiving the					
		ncident occurred. However	Γ,				
	she was unable to de	issing liquid morphine and	,				
	the allegation of drug		'				
		Administrator filed the					
		the local law enforcemen	nt.				
		of Nursing (NCBON), and					
	DHSR.						
	During a phone interv	riew conducted on 11/19/2	24				
		stated the 2 bottles of liqu					
	morphine sulfate were	·					
		4 evening. She had acces	ss				
		when she worked on					
		4. During the shift change	,				
		ecalled seeing 2 bottles o					
		e in its box and assumed					
	they were intact, seal	ed, and untampered. Whe	en				
	the DON called her or	n 03/30/24 asking her abo	out				
	the incident, she adm	itted that she did not chec	ck				
	both bottles of liquid r	•					
		ntact during shift transition	ı.				
	She stated she was b	eing reprimanded.					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DOILDING			
		NH0559	B. WING		C 11/20/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WILLOWE	ROOKE COURT SC CTF	AT TOYON ESTATE 619 LAUR	EL LAKE DRIV	E		
WILLOWE	NOOKE COOKT 3C CT	COLUMBI	JS, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
L 049	Continued From page	e 6	L 049			
	on 11/19/24 at 3:06 P she took over the me at shift change 03/29/boxes that contained during shift change na already an opened be sulfate in use for Resboth bottles were inta Nurse #2 opened the and checked the contopened and almost eremaining. The bottle manufacturer's seal wwas seen inserted on adapter that came wiremained unused in the did not have any reaspain medication. She lie detector test and was an 11/19/24 at 1:53 P assigned to work third AM) and relieved Nursecond shift (3:00 PM During the shift change that one bottle of Ressulfate had been ope contain 15 ml had less in the box with the cardisappeared. The bot while its own stopper unused in the box. St Director of Nursing (A immediately.	Is conducted with Nurse #4 IM. Nurse #4 stated when dication cart from Nurse #3 I/24, she did not open the liquid morphine sulfate arcotic count as there was oftle of liquid morphine ident #63. She assumed act and untampered. When 2 boxes of liquid morphine tent, one of the bottles was imptied, with less than 1 ml had been tampered as the was missing and an adapter the top of the bottle. The the liquid morphine sulfate he box. Nurse #4 stated she cons to steal Resident #63's offered a drug screening or was declined by the DON. Is conducted with Nurse #2 IM. She stated she was a shift (11:00 PM to 7:00 se #4 who had worked the I to 11:00 PM) on 03/29/24. See narcotic count, she found ident #63's liquid morphine ned. The bottle that should so than 1 ml left. It was sitting pon, but the seal had the had a stopper on the top and syringe remaining ne called the Assistant woon) to report the incident wiew conducted on 11/19/24				
		riew conducted on 11/19/24 recalled receiving the				

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TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		CONSTRUCTION	` ,	(X3) DATE SURVEY COMPLETED	
no real contraction						
	NH0559	B. WING		11,	C / 20/2024	
IAME OF PROVIDER OR SUPPLIER	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	•		
7.11.2 07 7 10 7 15 2 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1		19 LAUREL LAKE DRIV				
VILLOWBROOKE COURT SC CTR	AT TRYON ESTATE	OLUMBUS, NC 28722	_			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
o3/27/24 evening arousthe pink form (pharmal passed the medication completing the receiving assigned to relieve Nurself in the pink form (pharmal passed the medication completing the receiving assigned to relieve Nurself in the passed in the passed in the morphine sulf in the passed in the passe	I from the pharmacy on and 10:40 PM. She signed acy delivery receipt) and ans to Nurse #7 after sing process. As she was arse #7 at 11:00 PM that a shift change narcotic without opening the 2 box fate. Later, she counted to one with Nurse #3 during narcotic count without nen, she left the facility one. When she came back 24 in the evening, she rephine sulfate with Nurse seals or pulling out the seals of the boxes and checked transitions. See Conducted with Nurse #6 stated she should have of the boxes and checked the putting them into the seated she should have of the boxes and checked ey were not tampered. See putting them into the stated she should have of the boxes and checked ey were not tampered. See a shifts after 03/27/24 night the incident on 03/30/24. See the process of the state of the stated on 11/20/24 at the stopper that was the process of the state of the stopper that was the process of the state of the stopper that was the process of the stopper tha	es he g n to #3 d #7 d ne ht				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		NH0559		B. WING		1.	C 1/ 20/2024
	ROVIDER OR SUPPLIER	R AT TRYON ESTATE	619 LAURE	RESS, CITY, STA L LAKE DRIVI S, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L 049	of the nurses involved One of the nurses et screening or lie determined pharmacy immediate pharmacy immediate pharmacy immediate pharmacy staff a identify any wrongod dispensing, packagii. The facility unsubstate diversion and started controlled medicatio. During a phone internat 11:28 AM, the Phawas not with the phawas not with the phawas not with the phawas not with the phawas not elicated in a specific under the closed-circulation authorized staff were the controlled medication would be labeled, papellastic tote, and delivers to the facility. During an interview 12:33 PM, the Admir facility did not have a building. She felt that sulfate could have be the pharmacy. Howe the nursing staff did receiving the shipmer and was told that the totes were locked the pharmacy. The facility provided	delivery and receiving. Ned admitted any wrongd wen offered to have a dructor test. She notified the ly after the incident. The investigation that include and the delivery driver diverged along the processeng, delivery, and receiving along the allegation of danew tracking protocons. The explained all the answere dispensed, field area in the pharmacuit camera system. On a allowed to be there. A ations were dispensed, ackaged, put into a seal evered by the pharmacy!	loing. rug ne led all id not s from ng. f drug ol for 20/24 he nt cy ly the ffter all they ed s own at n the phine aving e it as hen macy d as s left	L 049			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. Boilbing.			
		NH0559		B. WING		1	C 1/20/2024
				ı			1/20/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WILL OWE	ROOKE COURT SC CTR	AT TRYON ESTATE	619 LAURE	L LAKE DRIV	E		
			COLUMBU	S, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
L 049	Continued From page	9		L 049			
	been affected by the of During shift change in bottle of morphine sultempty. The bottle shot sealed. The nurses at and the bottle unoper bottle out of the box at The Director of Nursin and came to the facility The resident was assed distress or uncontrolled Nursing reviewed the the electronic medical and confirmed that the medication doses. Shifted the possible properties of the properti	se residents found to ha	24, a po be alled e the hifts. fied ion. and rd, any ottle,				
	the same deficient provided when the Director of facility, she conducted narcotics, with no other A review of shift-to-sh completed from the tili arrived at the facility, The morphine arrived the cart on 03/27/24, both labeled correctly correct resident. The was empty. The information stopper, and clean sy All nurses identified from the tiling that the same that t	potential to be affected be actice: Nursing arrived at the d a 100% audit of all er discrepancies identific	ed. ne npty. d were t and ox. vere ews				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			TE SURVEY MPLETED		
							С
		NH0559		B. WING			11/20/2024
NAME OF P	ROVIDER OR SUPPLIER	S	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
\4/!! O\4/5			319 LAURE	L LAKE DRIV	E		
WILLOWE	BROOKE COURT SC CTR	RAI IRYON ESTATE	COLUMBU	S, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 049	Continued From page	÷ 10		L 049			
	local Sheriff's Departr (24-hour report) was to Personnel Registry per were assessed for party were within the normal	pottle. Report was filed we ment and initial allegation filed to the Healthcare er regulation. All residents in and vital signs, and the al limits. Resident #63, the med Medical Director were	s ey				
	systemic changes madeficient practice will Education was immed on the correct process diversion. 100% of nunarcotic count and divadministrative nurses proper check in processed proceding narcotics, of change and not assure sealed bottle, protectic allegations of diversion incorrect narcotic couprocedures, and the from substances. Competencies included narcotic count processed competencies were considered and 4/27/2 nurses who work as an Nurses were not allowed and competencies were	not recur: diately started for all nurs is of counting narcotics ar irses were educated on version, including . This education included edures with pharmacy checking all narcotics at s ming a closed box means ing oneself against on, process of reporting ints, investigation racility's policy on controlle cencies completed on 1006 in a medication cart. ed observation of correct lures. These education al	es and hift is a ed %				
	identified of not follow reconciliation. New "c	e issued for the nurses ving the policy on narcotic controlled substance	;				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 619 LAUREL LAKE DRIVE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ED.	LTIPLE CONSTRUCTION DING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 619 LAUREL LAKE DRIVE			NH0559	B. WING	i	_	
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE COLUMBUS, NC 28722			R AT TRYON ESTATE	619 LAUREL LAKE	DRIVE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FL	JLL PRE	PROVIDER	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
L 049 Pharmacy to schedule audits and medication observation to be completed with nurses on 05/20/24. The performance improvement plan initiated to monitor its effectiveness. After the investigation (5-day) was concluded, the results were sent to the Healthcare Personnel Registry. Not enough evidence to substantiate a drug diversion. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Narcotic reconciliation audits were conducted twice weekly for two weeks, weekly for four weeks, monthly for two months, and then randomly. The audits were conducted by the Director of Nursing, Assistant Director of Nursing, and Registered Nurse Supervisor on all shifts, including weekends. The audit included observation of shift-to-shift narcotic counts, assuring bottles were checked and not just looking at boxes, and counting refrigerated narcotics. Education and competencies proved successful in identifying any discrepancies. Education, competencies, audits, and performance improvement plan reviewed during Quality Assurance and Performance Improvement Committee meeting on 4/10/2024 and 7/10/2024. Compliance Date: July 15, 2024 3. Resident #68 was admitted to the facility on 10/07/19 with diagnoses including right shoulder pain. A review of the physician's order dated 05/15/23 revealed Resident #68 had an order to receive 1	L 049	Pharmacy to schedulobservation to be co 05/20/24. The performinitiated to monitor it investigation (5-day) were sent to the Heal Not enough evidence diversion. Indicate how the fact performance to make sustained: Narcotic reconciliation twice weekly for two weeks, monthly for the randomly. The audits Director of Nursing, and Registered Nursincluding weekends. observation of shift-the assuring bottles were looking at boxes, and narcotics. Education successful in identify Education, competed performance improved Quality Assurance as Improvement Command 7/10/2024. Compliance Date: July 3. Resident #68 was 10/07/19 with diagnorpain. A review of the physical succession of the physical succession of the physical succession.	le audits and medication impleted with nurses on mance improvement plass effectiveness. After the was concluded, the resulthcare Personnel Register to substantiate a drug elity plans to monitor its esure that solutions are on audits were conducted weeks, weekly for four wo months, and then is were conducted by the Assistant Director of Nurse Supervisor on all shift. The audit included on-shift narcotic counts, is checked and not just do counting refrigerated and competencies proving any discrepancies. Incies, audits, and ement plan reviewed during Performance ittee meeting on 4/10/20 ally 15, 2024.	n an ne sults stry. d a stry. d			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		NH0559	B. WING		C 11/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WILLOWE	BROOKE COURT SC CTF	R AT TRYON ESTATE	EL LAKE DRIV JS, NC 28722	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
L 049	Continued From page	e 12	L 049		
		noderate to severe chronic laily for right shoulder pain.			
	The quarterly MDS da Resident #68 with sev	ated 04/17/24 coded verely impaired cognition.			
	received 1 tablet of tra	revealed Resident #68 had amadol 3 times daily including 05/14/24 and			
	Resident #69 was admitted to the facility on 07/13/23 with diagnoses including chronic pain syndrome.				
	revealed Resident #6 tablet of Norco (a con consisting of an opioid and a non-opioid pair	d pain reliever hydrocodone n reliever acetaminophen for o severe pain) 7.5/325 mg			
	The quarterly MDS da				
	A review of the MARs revealed Resident #69 had received 1 tablet of Norco 7.5/325 mg 4 times daily throughout May 2024 including 05/14/24 and 05/15/24.				
	revealed Resident #6 tramadol from the phanarcotic count sheet MARs until 05/14/24. narcotic count on 05/14/88 should have 10 to	tic declining count sheet 8 had received 30 tablets of armacy on 04/13/24. The was consistent with the During the shift change 14/24 morning, Resident ablets of tramadol remaining ording to the narcotic count			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER. IDENTIFICATION NUMB		` '	CONSTRUCTION		E SURVEY PLETED
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		NH0559		B. WING		11	C I/ 20/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
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WILLOWE	BROOKE COURT SC CTR	R AT TRYON ESTATE		S, NC 28722	_		
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L 049	Continued From page 13			L 049			
	Resident #69 had red 7.5/325 mg from the paracotic count sheet was compared with the Martin The initial allegation revealed the facility be misappropriation of red 05/14/24 at 7:45 AM. by the Administrator to 3:00 PM. The DON was 05/14/24 that the nare incorrect at shift chan 2 tablets of tramadol missing. Nurse #1 who unable to explain what investigations, it was had been wasted by the The sharp container states.	report dated 05/14/24 ecame aware of the esidents' property on The incident was repo to DHSR on the same of the example of the	rco The The Tred Day at ing on Otal of vere The Was Norco Shift. Tablet				
	revealed Nurse #1 ware questions, having no pause before answer morning after the inciclarify what had happ medications but cons medication from the facility were monit sedation due to the inconfirm the location of	istently denied taking a acility. All the residents tored for increased pai nability of the facility to of those missing es were reported accor	he long ./24 to any s in n or				
	An attempt to conduc	t a phone interview wit Lat 1:46 PM was	h				

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	or riealth Service Regu		0.00		0.453 - :-	
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	בט
					С	
		NH0559	B. WING		11/20/	2024
		14110000			1 11/20/	2027
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		619 LAUF	REL LAKE DRIV	E		
WILLOWE	BROOKE COURT SC CTF	COLUMB	US, NC 28722			
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
L 049	Continued From page	2 14	L 049			
2010	Continued From page	2 17				
	unsuccessful. She did	d not return the call.				
		view conducted on 11/19/24				
		stated she came to the				
	_	M on 05/14/24 to relieve				
		performed narcotic count				
		, she recalled Nurse #1				
		ited it contained 2 tablets of				
		7.5/325 mg and tossed it				
	_ = -	ner before she had a chance				
		as upset and planned to				
	report the incident to	the Unit Manager (UM) later.				
		continued the narcotic				
	counting with Nurse #	#1. When they came to a				
	blister card of tramad	ol for Resident #68, the				
		was not in the binder with				
	other narcotic count s	sheets. Nurse #1 was unable				
		gful answer when she asked				
		of the narcotic count sheet.				
		re if the count sheet was				
		Nurse #1. Nurse #5 found				
	_	count sheet later in a drawer				
		room. The narcotic count				
	sheet indicated a bala					
		the blister card. However,				
	,	ets in the blister card. When				
		about the 2 missing tablets				
	· ·	ed she had wasted both				
		ified the findings to the UM				
		5 stated Nurse #1 was okay				
		er the shift to her about 12				
	_	4 evening. However, Nurse				
		onfused during the incident				
	on 05/14/24 in the mo	orning.				
		ducted with Resident #69 on				
		She recalled the incident				
		-May and stated she was				
		t, and the staff assessed her				
	pain level on the sam	e day. She denied having				

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AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O			CONSTRUCTION	(X3) DATE SU COMPLE	
		NH0559		B. WING		C 11/20	0/2024
NAME OF F	PROVIDER OR SUPPLIER			RESS, CITY, STA	•		
WILLOW	BROOKE COURT SC CTF	R AT TRYON ESTATE		EL LAKE DRIVI S, NC 28722	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
L 049	any problems getting and added the facility missing pain medicat An attempt to conduct #68 on 11/20/24 at 8: She was unable to an During an interview of 9:48 AM, the UM stat 05/14/24 morning as narcotic count sheet in She and Nurse #5 se station and finally fou count sheet in the medick review of the coof tramadol were miss to explain and did not had happened. She maffect, and she could was under any drug in Nurse #5 mentioned everify the 2 tablets of into the sharp contain took a peek into the short see any pills insiding immediately. An interview was con 11/20/24 at 10:08 AM called Nurse #1 on 05 she had a slurred sperespond to her questing mentioned she dropp floor and were wasted opened the sharp cormaintenance staff. The container and all the proper service in the start of the sharp cormaintenance staff. The container and all the properties of the sharp cormaintenance staff. The container and all the properties of the sharp cormaintenance staff. The container and all the properties of the sharp cormaintenance staff. The container and all the properties of the sharp cormaintenance staff. The container and all the properties of the sharp cormaintenance staff.	her pain medications so replaced and paid for hims after the incident. It an interview with Resides AM was unsuccessforwer questions. It an interview with Resides AM was unsuccessforwer questions. It an interview with Resides AM was unsuccessforwer questions. It an interview with Resides AM was unsuccessforwer questions. It an interview with Resides AM was unsuccessforwer questions. It an interview with Resides AM was unsuccessforwer questions. It an interview with Resides AM was unsuccessforwer with a large and the missing narcotic edication storage room. It an interview with Resides and the interview and the missing narcotic edication storage room. It an interview with Resides and the interview	dent dent dent dent dent dent dent dent	L 049			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB			CONSTRUCTION	(X3) DATE SU COMPLE	
				7. BOILDING.		C	
		NH0559		B. WING)/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET AND	RESS, CITY, STA	TE ZIP CODE		
NAME OF T	TOVIDER OR OUT FEER			L LAKE DRIV	•		
WILLOWE	ROOKE COURT SC CTR	RAT TRYON ESTATE		S, NC 28722	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
L 049	Continued From page	Continued From page 16					
L 049	happened. The DON separated the narcotic purposely and explair pulled the wrong sheef for finished controlled the facility might have indicated if a nursing controlled medication tramadol but something the missing 2 tablets of been given by Nurse by mistake, and the missing 2 tablets of been given by Nurse by mistake, and the missing 2 tablets of been given by Nurse by mistake, and the missing 2 tablets of been given by Nurse by mistake, and the missing 2 tablets of been given by Nurse by mistake, and the missing table of the missing 2 tablets of been given by Nurse by mistake, and the missing table of the missing staff to follow	denied Nurse #1 had a count sheet for trama hed Nurse #1 could have and put it at the right medications. She state medication errors and staff planned to divert so, they would not choosing stronger. She explain of tramadol might have #1 to residents in the fanissing 1 tablet of Norce ted and tossed in the transition. ducted with the MD on the stated he was not ided with the name of the stated Resident #63, and ided with the fanished immediately without the stated as the facility is emissing narcotic	re spot ed se ned acility b ash fied he # 68, any had	L 049			
		he pharmacy or during					
	- ·	he following corrective npletion date of 08/12/2	24:				
	been affected by the on Narcotic reconciliation plan proved successful	se residents found to ha	ment				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		NH0559		B. WING		11/20/2024	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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WILLOW	BROOKE COURT SC CTF	R AT TRYON ESTATE	COLUMBU	S, NC 28722			
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L 049	Continued From page	e 17		L 049			
	noticed missing from card. The off-going not communicate clearly medication during her Nursing was immedianurse was suspended. The identified resident no complaints. Her may signed out as given on medication administrated medications were wouther facility paid to reput the same deficient prowing the properties. The same deficient prowing the same deficient prowing the same deficient prowing the same deficient prowing the properties. The same deficient prowing the suspected nurse. The that the suspected nurse. The suspected nurse with the transhift, she wrote a state which was not missing dropped two Norco or in the sharps contained. The oncoming nurse pills, appearing to be the shift-to-shift count checked the sharps contained to the same shape No tramadol was note 100% audit of all narrow other discrepancies in tramadol and one No local Sheriff's Departing (24-hour report) filed Personnel Registry por suspensive programmed to the properties of the properties o	one resident's medicaturse was unable to what happened to r shift. The Director of ately notified. The susped, pending the investigat was assessed for pairorning dose of tramadount the narcotic sheet an ation record. Missing rth a nominal amount, adace them. It will identify other potential to be affected actice: Nursing arrived at the daphone interview with a phone interview with a Director of Nursing nourse had moments of slable to communicate who hadol. Before she left had ment mentioning Nord g. Stated she had preventhe floor, and wasted er, with the oncoming not confirmed that two whith Norco, were wasted dut. The Director of Nursicontainer, and only one and several Tylenol, who is size, and color of Nored in sharps container. Cotics completed with noted. Identified two mistro. Report filed with the ment and initial allegation.	ected ation. In with ol was dithe and by the and by the ation at the ation				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			CONSTRUCTION	(X3) DATE SUR COMPLETE	
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		NH0559		B. WING		11/20/2	2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WILLOWE	ROOKE COURT SC CTR	R AT TRYON ESTATE		L LAKE DRIV	E		
	I		COLUMBU	S, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
L 049	Continued From page	e 18		L 049			
	assessed for unusual and vital signs, and all Address what measur systemic changes madeficient practice will Education immediatel the correct process of diversion. 100% of nu controlled substance wasting of narcotics. completed between 0 ensuring to include nuneeded, or were on viallowed to work until the Pharmacy conduobserved medication as previously schedul	res will be put into place ade to ensure that the not recur: by started for all nurses of counting narcotics and urses were educated on policy, including proper This education was 5/14/24 and 05/31/24, urses who worked as acation. Nurses were not the education was compared to	on on I on ot olete.				
	to extend the audits a pass observations for including weekends, t audits were conducte and Registered Nurse On 05/20/24, another investigation) confider that the suspected nu undergoing ketamine post treatment caused unpredicted behavior The facility reviewed to North Carolina Board concluded that there were appared to the second of t	nurse (unrelated to this d in the Director of Nursurse was currently treatments, and the day d her to experience	ation The sing Sing y e at the sing th				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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		NH0559	B. WING		11	C / 20/2024
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NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STA			
WILLOWE	BROOKE COURT SC CTR	RAT TRYON ESTATE	AUREL LAKE DRIV JMBUS, NC 28722	E		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETE DATE
L 049	Continued From page	: 19	L 049			
	Nursing. The local Sh concluded that there v pursue diversion char					
	The suspected nurse was offered a personal leave (due to as needed job status, not eligible for Family Medical Leave Act) and offered support through our employer Carebridge Mental Health					
	through our employer Carebridge Mental Health program. She would require a medical release to return to work.					
	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:					
	Narcotic reconciliation twice weekly for two weeks, monthly for tw	_				
	randomly. It was cont performance improve	inued as with the previous ment plan, on a monthly an effective process. The				
	audits were conducte	d by the Director of Nursing r of Nursing on all shifts,				
	seven days that include					
	electronic medication documentation. Audit	conducted by the Director				
		tered Nurse Supervisor, d weekends. This was not				
	performance improve identifying this isolate	ment plan was successful in d narcotic discrepancy. Ad				
	05/15/24. Education, plan update, and aud Assurance and Perfo	tee meeting conducted on performance improvement its reviewed during Quality rmance Improvement				
	meeting on 07/10/24.					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		1 .	CONSTRUCTION	(X3) DATE SUF	
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		NH0559		B. WING		11/20/	2024
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
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WILLOWE	BROOKE COURT SC CTR	R AT TRYON ESTATE	COLUMBU	S, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
L 049	Continued From page 20			L 049			
	Compliance Date: Au	gust 12, 2024					
		re action plan with a 12/24 was validated on nterviews with the DON					
	An observation was conducted when a nurse was receiving medications delivered from the pharmacy. The nurse checked each medication by matching the name of medication, strength, quantity, and expiration date before signing the pink sheet. The delivery did not include any controlled medications in the liquid form. No concerns noted.						
	An observation was conducted during a shift transition for a medication cart between 2 nurses. Nurses started by counting the total number of blister cards that contained controlled medications in thedouble-locked compartment in the medication cart and verified the balance in the narcotic count sheet. Then, they counted each blister card of controlled medication to ensure the quantity listed in the narcotic count sheet was consistent with the actual counts. All the liquid controlled medications were pulled from the box to ensure it was untampered and the volume of liquid consistent with the narcotic count sheet. After all the counts were completed without any issues, the incoming nurse signed the controlled medication count sheet before the outgoing nurse passed the medication cart key to her.						
	from 11/18/24 to 11/19 medications, 6 differe Nurses. The nurses w controlled medication	ervations were conducte 9/24. It consisted of 25 ent residents, and 2 differ vere observed storing s in the double-locked nedication cart, docume	erent				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		NH0559	B. WING		C 11/20/2024
					11/20/2024
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA		
WILLOWE	BROOKE COURT SC CTR	RAT TRYON ESTATE	EL LAKE DRIVI	Ē	
			S, NC 28722		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
L 049	Continued From page	21	L 049		
	the retrieval of controlled medication according to the facility's protocol, and using the correct technique as ordered when administering controlled medications. No medication errors were identified during the observation.				
	Nursing staff confirmed they had received in-service trainings related to controlled substance policy and procedures, including proper wasting of narcotics, correct process of counting narcotics, proper check in procedures with pharmacy regarding narcotics, appropriate process to count all narcotics at shift change, protecting oneself against allegations of diversion, and process of reporting incorrect narcotic counts. Nursing staff were assigned to review the policy and procedures handout prior to the training. The training was conducted in-person by DON and ADON, and it included multiple examples and scenarios.				
	in-service immediatel re-educate all the lice receiving procedures pharmacy, proper procontrolled medication proper process of har incorrect narcotic coulincident, she introduct sheet for proper documedications. She refor proper procedures medications and the pempty blister card for the medication cart all pass randomly to ensicounts were conducted count sheets were do	s during shift change, and ndling and reporting nts. After the second ed a new narcotic tracking mentation of controlled educated all the nursing staff			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		NH0559	B. WING		C 11/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WILLOWB	ROOKE COURT SC CTR	R AT TRYON ESTATE	EL LAKE DRIV S, NC 28722	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
L 049	not have any more in	ccessful as the facility did	L 049		
L 098	10A-13D.2306 (d) The ensure that procedure minimizing medication include, but are not lin following: (8) The facility shall montrolled substances	es aimed at n error rates	L 098		12/17/24
	resident, staff, and the facility failed to verify 2 bottles of controlled them from the pharma narcotic counts. The faccurate record of cofailed to follow proper contaminated controll a bottle of liquid morp almost empty 3 days pharmacy and 3 table went missing from a residents reviewed for	ew and interviews with e Medical Director (MD), the the quantity and integrity of medications when receiving acy and during shift change facility also failed to keep an introlled medications and procedures when wasting ed medications. As a result, whine sulfate was found after receiving it from the ets of controlled medications medication cart for 3 of 3 r pharmacy services ent #68 and Resident #69).		Upon identification of unaccounted for liquid morphine, investigation started immediately by the Director of Nursing (DON). Initial allegation (24 hour) reposent to the Healthcare Personnel Reg (3/30/2024). Polk County Sheriff□s Department contacted and deputy on campus to file report (3/30 /2024). The pharmacy and medical director were notified. On 3/30/2024 around 1230am, an aud was conducted by the DON on 100% narcotics. No further discrepancies identified. Education on policy of appropriate handling of controlled substances, and	ort istry

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB			CONSTRUCTION	(X3) DATE SUF COMPLETI	
				_		c	
		NH0559		B. WING		11/20/	2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	JE ZIP CODE		
	10115211 011 001 1 2.2.1			L LAKE DRIV	,		
WILLOWB	ROOKE COURT SC CTR	AT TRYON ESTATE		S, NC 28722	_		
(X4) ID		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETE DATE
L 098	Continued From page	23		L 098			
	1. Resident #63 was a 09/18/23 with diagnos and fibromyalgia. She 04/12/24. A review of the physic revealed Resident #6 0.5 milliliters (ml) of lic milligrams (mg)/5 ml c needed for pain or short The quarterly Minimus 03/21/24 coded Resid cognition. A review of the pharm 03/27/24 revealed the bottles of liquid morph analgesic for the relie acute and chronic pai	eadmitted to the facility of ses including low back per expired in the facility of sian's order dated 03/18/3 had an order to receive quid morphine sulfate 1 once every 1 hour as ort of breath. In Data Set (MDS) date dent #63 with an intact are pharmacy had delivered in sulfate (an opioid of of moderate to severe n) 100 mg/5 ml that	pain on 3/24 ve 00 ed ted ed 2		use of new narcotic sign in sheet was started on 3/30/2024 for nurses. Education was conducted by the DON assistant director of nursing (ADON) a completed on 4/27/2024. Education or appropriate handling of controlled substances was also conducted by the DON and ADON and completed on 4/27/2024. Reeducation on the policy of appropria handling of controlled substances to be conducted for nurses. Re-education where the provided by the DON and ADON and completed by 12/17/2024. Nurses will be allowed to work after this date until education is completed. Education is a received upon hire, annually, and as needed.	and n e ate e vill nd not	
		ch bottle for Resident # uid morphine sulfate we by Nurse #6.			Audits on narcotic reconciliation and appropriate handling of narcotics were conducted twice weekly for four weeks	3,	
	revealed Resident #6 liquid morphine sulfate 03/27/24 and 03/28/24	nistration records (MAR 3 had received 1 doses e 2 times as needed or 4, and 3 times as need id not indicate she had e on 03/30/24.	s of n		weekly for four weeks, and monthly fo three months by the DON and ADON. Audits included direct observations of handling of narcotics and shift-to-shift transitions. These audits started 3/30/ and concluded 8/12/24. Audits and findings were discussed at QAPI meet on 4/10/24, Ad HOC QAPI meeting or	the 24 tings	
	Nurse #2, Nurse #3, Nurse #7 had access morphine sulfate from with the following time - 03/27/24 at 10:40 Preceived the pharmace	M, Nurse #6 signed an y delivery including 2 b	d d 60/24 d oottles		5/15/24, and 7/10/24. Audits including observations of signir and the handling of narcotics will be conducted twice weekly for two weeks then weekly for four weeks, then randomly. Audits will be conducted by DON and ADON. Results from these	ng in	
	of liquid morphine sul	fate. She passed the 2			audits will be presented at the January	/	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE S COMPLI	
			A. BOILDING.			
		NH0559	B. WING		1	, 0/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WILLOWE	ROOKE COURT SC CTR	R AT TRYON ESTATE	L LAKE DRIV	E		
		COLUMBU	S, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
L 098	Continued From page	24	L 098			
	immediately.	nine sulfate to Nurse #7		2025 and April 2025 quality assurance meetings.	e	
	shift change narcotic taking over the medica - 03/27/24 from 11:00 Nurse #6 had access - 03/28/24 from 7:00 had access to the me - 03/28/24 from 7:00 had access to the me - 03/29/24 from 7:00 had access to the me - 03/29/24 from 3:00 had access to the me - 03/29/24 around 11 Nurse #4 and noticed morphine sulfate that almost empty during to count. During a phone intervat 2:11 PM, Nurse #3 morphine sulfate were pharmacy on 03/27/2 to the medication card 03/28/24 and 03/29/2	O PM to 03/28/24 7:00 AM - to the medication cart. AM to 11:00 PM, Nurse #3 dication cart. O PM to 03/29/24 7:00 AM, to the medication cart. AM to 3:00 PM, Nurse #3 dication cart. PM to 11:00 PM, Nurse #4 dication cart. :00 PM, Nurse #2 relieved that one bottle of liquid should contain 15 ml was the shift change narcotic riew conducted on 11/19/24 stated the 2 bottles of liquid e delivered from the 4 evening. She had access t when she worked on 4. During the shift change		Completion date 12/17/2024		
	liquid morphine sulfat they were intact, seal the DON called her or	recalled seeing 2 bottles of e in its box and assumed ed, and untampered. When n 03/30/24 asking her about itted that she did not check				
	both bottles of liquid r	morphine sulfate and ntact during shift transition.				
	on 11/19/24 at 3:06 P she took over the me	s conducted with Nurse #4 M. Nurse #4 stated when dication cart from Nurse #3 '24, she did not open the				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S	
				A. BOILDING			^
		NH0559		B. WING		1	C 20/2024
NAME OF D	ROVIDER OR SUPPLIER	•	STREET AND	RESS, CITY, STA	TE ZIR CODE		
NAME OF T	NOVIDEN ON 3011 EIEN			L LAKE DRIV	,		
WILLOWE	BROOKE COURT SC CTF	R AT TRYON ESTATE		S, NC 28722	_		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)		COMPLETE DATE
L 098	Continued From page	e 25		L 098			
L 098	boxes that contained during shift change na already an opened be sulfate in use for Res both bottles were inta Nurse #2 opened the and checked the contopened and almost e remaining. The bottle manufacturer's seal was seen inserted on adapter that came wir remained unused in the did not have any reaspain medication. She lie detector test and was a pain medication. She lie detector test and was an 11/19/24 at 1:53 Passigned to work third AM) and relieved Nursecond shift (3:00 PM) During the shift change that one bottle of Ressulfate had been ope contain 15 ml had less in the box with the cardisappeared. The botwhile its own stopper unused in the box. She Director of Nursing (A immediately.	liquid morphine sulfate arcotic count as there wontle of liquid morphine ident #63. She assume act and untampered. What is a boxes of liquid morphitent, one of the bottles womptied, with less than 1 had been tampered as was missing and an adapt the top of the bottle. The had been tampered as was missing and an adapt the top of the bottle. The had been tampered as was missing and an adapt the top of the bottle. The box. Nurse #4 stated shows to steal Resident #600 offered a drug screening was declined by the DO was conducted with Nurse PM. She stated she was deshift (11:00 PM to 7:00 of see #4 who had worked with the 11:00 PM) on 03/25 of ge narcotic count, she fistedent #63's liquid morphined. The bottle that shows than 1 ml left. It was so pon, but the seal had title had a stopper on the and syringe remaining the called the Assistant ADON) to report the incitative conducted on 11/1	d nen nine was I ml s the spter he ulfate d she 63's ng or N. e #2 0 the 8/24. ound hine buld sitting e top	L 098			
	at 3:32 PM, Nurse #6 medications delivered	recalled receiving the differ the pharmacy on	I				
		und 10:40 PM. She sig					
	passed the medicatio	acy delivery receipt) and ons to Nurse #7 after ring process. As she wa					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB			CONSTRUCTION	(X3) DATE SU COMPLE	
				7 t. BOILBING.			
		NH0559		B. WING		11/20	/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	to vibert of tool i eleft			L LAKE DRIV			
WILLOWE	ROOKE COURT SC CTR	R AT TRYON ESTATE		S, NC 28722	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
L 098	Continued From page	26		L 098			
L 098	assigned to relieve Nonight, she conducted count with Nurse #7 vof liquid morphine sult 2 boxes of liquid morphine boxes. The counted the liquid mowithout checking the state of the seals during shift. A phone interview was on 11/19/24 at 4:37 Passed 2 bottles of liquid mowithout checking the seals during shift. A phone interview was on 11/19/24 at 4:37 Passed 2 bottles of liquid mowithout checking the seals during shift. A phone interview was on 11/19/24 at 4:37 Passed 2 bottles of liquid were tightened up wit 03/27/24 before 11:00 open the boxes before medication cart. She spulled the bottles out the seals to ensure the did not work any othe until she heard about. During an interview could be the seal of the pain medication. Simmediately after the started the investigation back to the night of deference on the pain medication. Simmediately after the started the investigation back to the night of deference on the pain medication. Simmediately after the started the investigation back to the night of deference on the pain medication of the nurses every one of the nurses every one of the nurses every of the pain medication of the nurses every one of the nurses every one of the nurses every of the pain medication of the nurses every one of the nurses every o	urse #7 at 11:00 PM that a shift change narcotic without opening the 2 befate. Later, she counted on the with Nurse #3 durnarcotic count without hen, she left the facilitying. When she came back in the evening, she rephine sulfate with Nurse seals or pulling out the sto ensure they were stated she should have of the boxes and check transitions. Se conducted with Nurse M. She recalled Nurse quid morphine sulfate the rubber bands to her compared to the boxes and check transitions. Se conducted with Nurse will be putting them into the stated she should have of the boxes and check ey were not tampered. It is shifts after 03/27/24 in the incident on 03/30/2 to onducted on 11/20/24 at tated the stopper that we define the stopper that we define the stated all the wellivery and receiving. Note that the stopper that we consider the stopper that we define the stopper that we consider the stopper that we consid	oxes d the ring on ick to se #3 ve ked e #7 #6 hat on k or e ked She hight 24. at vas ifate en icility and vay lone oing. Jg	L 090			
	screening or lie detec	tor test. She notified the yafter the incident. The	e				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPL	
				B. WING		1	
		NH0559		B. WING		11/2	20/2024
	OVIDER OR SUPPLIER	RAT TRYON ESTATE	619 LAURE	RESS, CITY, STA EL LAKE DRIVI S, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	the pharmacy staff an identify any wrongdoin dispensing, packaging. The facility unsubstant diversion and started controlled medication: During a phone intervat 11:28 AM, the Pharmacy and the controlled medication: packaged in a specific under the closed-circulation authorized staff were the controlled medication authorized staff were the controlled medical would be labeled, packaged in the facility. During an interview of the pharmacy. However, the pharmacy. However, the nursing staff did not not have a staff the pharmacy. However, the totes were locked the pharmacy. 2. Resident #68 was a 10/07/19 with diagnosity pain. A review of the physical and the pharmacy.	nvestigation that included the delivery driver did ng along the processes g, delivery, and receiving that the allegation of a new tracking protocos. Tiew conducted on 11/2 macy Manager stated macy when the inciden the delivery all the	d not s from ng. drug ll for 0/24 he t sy y the fter all theyed sown at a the phine aving e it as nen macy as left on alder 5/23	L 098			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
ANDIEAN	or Contraction	IDENTIFICATION NOMBER.	A. BUILDING: _		J CONTIL	-120
		NH0559	B. WING		11/2	; 0/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WILLOWE	ROOKE COURT SC CTR	RAT TRYON ESTATE	EL LAKE DRIV JS, NC 28722	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
L 098	Continued From page	: 28	L 098			
		noderate to severe chronic laily for right shoulder pain.				
	The quarterly MDS da Resident #68 with sev	ated 04/17/24 coded verely impaired cognition.				
	received 1 tablet of tra	revealed Resident #68 had amadol 3 times daily including 05/14/24 and				
		mitted to the facility on ses including chronic pain				
	revealed Resident #6 tablet of Norco (a con consisting of an opioid and a non-opioid pain	d pain reliever hydrocodone reliever acetaminophen for severe pain) 7.5/325 mg				
	The quarterly MDS da Resident #69 with inta					
	received 1 tablet of N	revealed Resident #69 had orco 7.5/325 mg 4 times 2024 including 05/14/24 and				
	revealed Resident #6 tramadol from the pha narcotic count sheet v MARs until 05/14/24. narcotic count on 05/14/24 should have 10 ta	ic declining count sheet 8 had received 30 tablets of armacy on 04/13/24. The was consistent with the During the shift change 14/24 morning, Resident ablets of tramadol remaining ording to the narcotic count				

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LETED
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C 20/2024
0/5)
(X5) COMPLETE DATE

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, ,		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				A. BOILDING			0	
		NH0559		B. WING		11	C 1/ 20/2024	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
			619 LAURE	L LAKE DRIV	E			
WILLOWE	BROOKE COURT SC CTF	R AT TRYON ESTATE	COLUMBU	S, NC 28722				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
L 098	Continued From page	e 30		L 098				
	hours ago on 05/13/2 #1 appeared to be co on 05/14/24 in the mo	4 evening. However, N Infused during the incid Infing.	ent					
	11/20/24 at 8:43 AM. that happened in mid- notified of the inciden	ducted with Resident # She recalled the incide -May and stated she want, and the staff assessed day. She denied have	ent as ed her					
	any problems getting and added the facility	her pain medications s replaced and paid for	o far					
		ions after the incident. It an interview with Res	ident					
	·	48 AM was unsuccessi						
	She was unable to ar							
	9:48 AM, the UM stat 05/14/24 morning as narcotic count sheet if She and Nurse #5 se station and finally fou count sheet in the me quick review of the coof tramadol were miss to explain and did not had happened. She raffect, and she could was under any drug in Nurse #5 mentioned serify the 2 tablets of into the sharp contain took a peek into the s	onducted on 11/20/24 and Nurse #5 texted here she could not find the for Resident #68's trammarched all over the nurse and the missing narcotic edication storage room. Ount sheet revealed 2 takes ing. Nurse #1 was unauted try to explain why and ecalled Nurse #1 had anot confirm whether she influence at that time. We she did not have a chain Norco that Nurse #1 to the in front of Nurse #5, sharp container and coule. Then she called the	adol. se A ablets able what a flat le /hen nce to ssed she					
	11/20/24 at 10:08 AM	ducted with the DON o l. She recalled when sh 5/14/24 after the incide eech and was slow to	е					

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SI COMPLE	
			7. BOILBING.			
		NH0559	B. WING		11/2	0/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WILLOWE	ROOKE COURT SC CTR	8 AT TRYON ESTATE	L LAKE DRIV	E		
		COLUMBU	S, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
L 098	Continued From page	31	L 098			
	respond to her questi mentioned she dropp floor and were wasted opened the sharp cormaintenance staff. The container and all the plant tablet of Norco. She she was unable to exhappened. The DON separated the narcoti purposely and explain pulled the wrong sheef or finished controlled the facility might have indicated if a nursing controlled medication tramadol but somethin the missing 2 tablets been given by Nurse by mistake, and the narcoti mentioned to the facility might have indicated if a nursing controlled medication tramadol but something the missing 2 tablets been given by Nurse by mistake, and the narcotic mentioned to the facility might have indicated if a nursing controlled medication tramadol but something the missing 2 tablets been given by Nurse by mistake, and the missing the facility might have a facility might have indicated in the fac	ed 2 tablets of Norco on the d in the sharp container, she hatainer with the help of the here were 7 pills in the sharp poills were Tylenol except for e called Nurse #1 again and plain why and what had denied Nurse #1 had c count sheet for tramadol hed Nurse #1 could have et and put it at the right spot medications. She stated e medication errors and staff planned to divert s, they would not choose high stronger. She explained of tramadol might have #1 to residents in the facility hissing 1 tablet of Norco ted and tossed in the trash				
	11/20/24 at 10:35 AM of the incidents on 04 respectively and provresidents affected. He and #69 were assess adverse consequence adequate supply of the medications. He addernedications were repfacility later. It was his nursing staff to follow count and verify contreceiving them from the shift transition and follows.	ided with the name of the e stated Resident #63, # 68, ed immediately without any es noted as the facility had be missing narcotic ed all the missing laced and paid for by the expectation for all the the facility's protocol to colled substances when the pharmacy or during a lowed the facility's redocumenting and wasting				

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PRINTED: 12/11/2024

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING __ NH0559 11/20/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **619 LAUREL LAKE DRIVE** WILLOWBROOKE COURT SC CTR AT TRYON ESTATE

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE

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