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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to make repairs to walls, door casing, electrical outlets, and window blinds, and failed to keep a bathroom and heating unit clean for 5 of 10 rooms on the Hickory Hall locked unit (rooms 206,207,209,210 and 211). Findings included: 1. Observation on 1/6/15 at 9:09 AM revealed small pieces of trash and heavy dust in the vent of the heating and air conditioning unit in room 207. 2. Observation on 1/6/15 at 9:36 AM revealed dry wall joint compound exposed to the left side of the bathroom door and above heating and air conditioning unit, the bathroom had a strong urine odor with a rusty build up around the base of the toilet in room 210. 3. Observation on 1/6/15 at 9:46 AM revealed that the blinds on the window were broken on the bottom left side and the bottom 9 panels would not lower and the corner of the wall on the right side of the bathroom door had a quarter size hole exposed with dry wall joint compound filler exposed around the hole in room 211. 4. Observation on 1/6/15 at 2:11 PM revealed that the door casing to the door exiting the room on the right side was loose and pulled from the wall approximately 2 inches and the outlet cover behind Bed-A was missing in room 206. 5. Observation on 1/6/15 at 2:44 PM revealed a	F 253	Housekeeping & Maintenance Services Heavy dust in the vent of the heating and air conditioning unit in room 207 J cleaned 1/14. Dry wall joint compound exposed to the left side of the bathroom door and above heating and air conditioning unit Completed 1/27. The bathroom had a strong urine odor with a rusty build up around the base of the toilet in room 210 J Floor cleaned and toilet re-caulked Completed 1/29. The blinds on the window were broken on the bottom left side and the bottom 9 panels would not lower J New blinds put up Completed 1/9. The corner of the wall on the right side of the bathroom door had a quarter size hole exposed with dry wall joint compound filler exposed around the hole in room 211 - Repairs 1/30. The door casing to the door exiting the room on the right side was loose and pulled from the wall approximately 2 inches - Completed 1/27. The outlet cover behind Bed-A was missing in room 206 - Completed 1/9. Loose piece of metal on the corner of the wall at the left side of the bathroom exposing a sharp corner and sticking out from the wall about 1 inch in room 209 - Completed 1/27. The bathroom in room 210 was cleaned around the toilet and	2/2/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/02/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 253	Continued From page 1 loose piece of metal on the corner of the wall at the left side of the bathroom exposing a sharp corner and sticking out from the wall about 1 inch in room 209. An interview with Nurse Aide #6 on 1/8/15 at 1:30 PM revealed that if any repairs are needed that she reports it to the supervisor and writes it on the maintenance clip board at the nurse ' s station for 100 and 300 halls. If the repair needs quick attention the nurse will page maintenance over the intercom. An interview with Nurse #3 on 1/8/15 at 1:34 PM revealed that he contacts maintenance verbally if any repairs are needed. Nurse #4 was not aware of any forms to complete for maintenance repairs that are needed. An interview with Housekeeping Aide #1 on 1/8/15 at 1:39 PM revealed that she is in resident rooms every morning and if a repair is needed she reports it to her supervisor or to maintenance staff. Housekeeping Aide #1 further indicated that she was not aware of any maintenance forms to complete to request repairs, she communicate to maintenance verbally. On 1/8/15 at 2:00 PM the maintenance clip board was reviewed. The clip board was labeled " Maintenance Request " and the sheet identified the room number, the maintenance repair requested and the date it was corrected with the maintenance staff initials. The sheet revealed two notations for hickory Hall nurse ' s station repairs. There were no repairs requested for resident rooms. An interview with the administrator on 1/8/15 at 2:05 PM revealed that the clip board was the mode of communication to maintenance along with " Homework sheets " that are completed and reviewed each morning in morning meeting. The activity director is assigned to make rounds	F 253	re-caulked 1/28. Audit of Rooms having the potential have been identified and given to the Maintenance Director Completed 2/1. Re-education of staff related to communicating to Housekeeping & Maintenance Completed 2/1. Clip boards are maintained at the nursing stations to log any Housekeeping & Maintenance concerns. Preventive Maintenance room check sheet will be used weekly by Maintenance Director of Designee. This Quality Improvement Monitoring will be used to select 4 rooms each week for 12 weeks. Results of the Quality Improvement Monitoring will be discussed at the monthly Quality Assurance Performance Improvement Committee Meeting for three months. The committee will recommend revisions to the plan to sustain substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 253	Continued From page 2 each morning on the Hickory Hall and completes the ' Homework Sheet " on items that need to be addressed. The " Homework Sheet " is brought to morning meeting each morning. A second observation was completed on the identified areas with the administrator on the Hickory Hall on 1/8/15 at 2:10 PM and he agreed that the door casing in room 206 was loose from the wall and he popped it back into place, he indicated that some of the door casings pop off easily and some are secured with a screw. The administrator agreed that the corner metal was loose in room 209 that exposed a sharp corner and indicated that it would be taken care of today (1/8/15). The administrator further indicated that a lot of the corners have wear and tear, the building is 20 years old and a renovation plan is in place. During an observation of the bathroom in room 210, he agreed that there was a urine odor and stain around the toilet and that it would be cleaned and re-caulked.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		2/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 279	Continued From page 3	F 279		

psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interview the facility failed to provide contracture management for 1 of 4 sampled residents (Resident #29) who experienced changes in bilateral knee contractures.

The findings included;

Resident #29 was admitted to the facility on 4/6/10 with a diagnosis that included Alzheimer ' s disease, hypertension, osteoporosis, senile dementia, muscle weakness, abnormal posture. The most recent Minimum Data Set (MDS) assessment dated 11/25/14 revealed Resident #29 had impairments on both side of the lower extremities and required extensive assistance to complete activities of daily living. The MDS further indicated Resident #29 had severely impaired cognition.

Review of Resident #29 care plan dated 11/25/14 revealed no care plan in regards to contracture management or range of motion (ROM).

Review of Resident #29 ' s Initial Physical Therapy Evaluation dated 8/22/13 revealed diagnoses of abnormal posture and contracture of joints (s) of her lower leg.

Resident #29 was evaluated by Physical Therapy and Occupational Therapy on 1/7/15. Physical and Occupational Therapy began treating Resident #29 on 1/7/15 and plans to continue physical therapy 5 times a week and occupational therapy three times a week for 30 days or as long as necessary. Resident #29 comprehensive care plan was updated on 1/27/15. The comprehensive care plan includes intervention to perform passive range of motion to extremities during ADL care.

Residents currently residing in the facility who have the potential to be affected. The Minimum Data Set Coordinator (MDSC) has conducted a review of the care plans for current residents residing in the facility on or before 1/30/15 to ensure that residents having limited range of motion are updated.

The MDSC was in-serviced on 1/27/15 by the Regional Case Mix Coordinator to ensure proper coding of upper extremity and lower extremity impairments and corresponding care plans in place related to management of potential complications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX 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) COMPLETION DATE
F 279	Continued From page 4 Review of Resident #29 ' s Interdisciplinary Therapy Screen dated 9/2/14 stated restorative nursing assistant (NA) reports patient had increased tightness with hip abduction. Requested hip orthotic for positioning. Interview of Nursing Assistant (NA) #1 on 1/6/15 at 3:35 pm indicate that Resident #29 had contractures of her legs. NA#1 stated Resident # 29 did not utilize any splinting device. NA #1 indicated she did not provide Resident #29 with Range of motion. Interview with NA #2 on 1/7/14 at 8:50 am revealed Resident #29 had contractures in both of her knees. The NA stated Resident #29 legs were tight and stayed in a bent position making it difficult when bathing Resident #29. NA#2 stated that she worked with Resident #29, but had never observed her to wear any splinting device. NA#2 indicated restorative provided range of motion services. Interview with the MDS Coordinator on 1/7/15 at 9:58 am revealed Resident #29 did not have a care plan for contractures or contracture manager. The MDS Coordinator indicated that she only care planned residents for contractures unless the resident has a splint ordered or in the instance the resident has been placed on restorative care for ROM. The MDS coordinator further revealed during her annual assessment she coded the resident as having lower limb impairments due to the resident being contracted in her knees. Interview with the Director of Nursing (DON) on 1/8/15 at 4:09 pm revealed she was unaware Resident #29 did not have a care plan in regards	F 279	secondary to immobility. Quality improvement monitoring will be conducted by the Director Clinical Services/ Administrative Nurse three times a week per week for four weeks, then two times per week for four weeks, then weekly for four weeks to ensure that residents with limited range of motion have limitations documented in the care plan. Results of the Quality Improvement monitoring will be discussed by the Quality Assurance Performance Improvement Committee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The QAPI committee will discuss any necessary revisions to the plan to sustain substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX 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) COMPLETION DATE
F 279	Continued From page 5 to her bilateral contractures. It was the expectation of the DON that residents have a care plan for contractures.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide a positioning device to a wheelchair for one of one sampled residents requiring a positioning device in the wheelchair. Resident #43 The findings include: Resident # 43 was admitted to the facility on 12/3/13 with diagnoses of stroke, dementia, diabetes and difficulty in walking. Resident #43 received occupational therapy (OT) from 12/4/13 to 4/15/14. Review of the OT discharge summary dated 4/15/14 indicated Resident #43 had required supervision for bathing of the upper body, moderate assistance with dressing of the upper body, minimal assistance with toileting and contact guard with transfers. The discharge summary included a " Summary of Progress: Patient has reached	F 309	Resident #43 was evaluated by Physical Therapy on 1/15/15 and Occupational Therapy on 1/12/15. Physical Therapy began treating Resident #43 on 1/15/15 and plans to continue physical therapy 5 times a week for 4 weeks. Occupational therapy began treating Resident #43 on 1/12/15 and plans to continue for 5 times a week for 4 weeks or as long as necessary. Orthotic management was an intervention for Occupational Therapy. Residents currently residing in the facility have the potential to be affected. Current nursing staff were in-serviced by the Director of Clinical Services on 1/30/15 regarding the need to apply positioning devices as ordered. An assessment of positioning for residentJ s in wheelchairs was completed on 1/28/15	2/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX 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) COMPLETION DATE
F 309	Continued From page 6 optimal functional level and is not appropriate for a Restorative Nursing Program. Hall nursing staff have been educated on how to assist patient during functional activities to maximize independence and decrease the care giver burden of care. " Recommendations for equipment upon discharge included use of a right arm trough to assist with positioning of the right arm while up in a wheelchair (except at mealtime). The annual Minimum Data Set (MDS) dated 11/4/14 indicated Resident #43 had short and long term memory problems. No moods or behaviors were exhibited. Resident #43 had problems with unclear speech and usually understood others and could be understood. This MDS assessed Resident #43 as requiring extensive assistance of two staff members for transfers, dressing, personal hygiene and bathing. There was impairment of the functional movement in the lower extremity on one side. The resident ' s care plan with an update of 11/13/14 did not include the use of a right arm trough to assist with positioning of the right arm while up in a wheelchair. Observations on 01/06/15 at 10:40 AM revealed Resident #43 was seated in a wheelchair with the right arm wedged between the side of wheelchair and trunk of his body. He was observed using his left hand to help to move the right hand. The right hand was slightly swollen as compared to the left. No positioning device was in place for the right arm during this observation. Observations on 1/7/15 at 11:24 AM revealed Resident #43 was seated in a wheelchair with the	F 309	through 1/30/15 by the unit manager and a staff nurse. ResidentJ s with a deficit were referred to therapy for a screen and possible treatment. When a therapy is discontinuing a treatment plan, the therapist will discuss the needs and recommendations for the resident relative to the need for maintenance positioning. The Director of Clinical Services/Administrative Nurse and Therapy Director will review the medical record including the care plan for residents that are having Therapy discontinued for (five) residents per week for (twelves) weeks to ensure that interventions are implemented as indicated and to ensure positioning devices are in place. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Unit Manager to the Quality Assurance Performance Improvement Committee monthly for 3 months. The QAPI committee will recommend revisions as indicated to sustain substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	**01/08/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 309	Continued From page 7 right arm down by his side in the wheelchair. There was no positioning device in place for the right arm during this observation. Interview with nurse #1 on 01/08/15 at 11:10 AM revealed she could not remember when she saw the arm trough last. She explained she knew he had it at one time. Interview with therapy staff member on 01/08/15 at 11:10 AM indicated Resident #43 had an arm trough due to hand swelling and the arm was dangling down by the wheel on the wheelchair. Further interview revealed therapy had not screened the resident in the recent months since he had been discharged. The therapy staff member was not aware the hand was swelling and wedged in the wheelchair between the side of the chair and the resident's trunk. She explained she would do a screen for Resident #43. Interview on 01/08/15 at 1:18 PM with the Director of Nursing revealed Resident #43 could raise his right arm. She explained the method of communication between nursing and therapy consisted of using a communication form. The Director of Nursing further explained any recommendations from therapy would be given to her. She would inform the nurses and the therapist would tell the nurses. The Director of Nursing explained her expectations of the nurse would be to have the arm trough replaced. Interview on 01/08/15 at 2:26 PM revealed nurse #5 found the right arm trough in the resident's room. Nurse # 4 explained she did not know why it had not been applied to the wheelchair.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX 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) COMPLETION DATE
F 309	Continued From page 8 Interview on 01/08/15 at 2:35 PM with the Director of Nursing indicated there was no order for the right arm trough. She explained without an order the nursing staff would not know to apply it.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide personal hygiene of a facial shave for one of five sampled residents dependent on staff for care. Resident #43. The findings include: Resident # 43 was admitted to the facility on 12/3/13 with diagnoses of with stroke, dementia, diabetes and difficulty in walking. The Minimum Data Set (MDS) dated 11/4/14, an annual, indicated Resident #43 had short and long term memory problems, no moods or behaviors were exhibited and walking in his room or hallway did not occur. This MDS assessed Resident #43 as requiring extensive assistance of two staff members for transfers, dressing, personal hygiene and bathing. The care plan dated 11/13/14 included a problem	F 312	Resident #43 received a facial shave and shower on 1/7/15 by a CNA on 3-11 shift. Residents currently residing in the facility have a potential to be affected. Current nursing staff was in-serviced by the Director of Clinical Services on 1/30/15 regarding shower/bath schedule and documentation of ADL care to include refusal of care by resident. The Director of Clinical Services/Administrative Nurse will review the ADL documentation for (five) residents per week for (twelve) weeks to ensure that ADL care is provided and documented. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Unit Manager to the Quality Assurance Performance Improvement Committee monthly for 3	2/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 312	Continued From page 9 of self care deficit related to general muscle weakness and lack of coordination. The stated goal indicated the resident would assist with activities of daily living (ADLs) care every day as tolerated. The approaches included rehab according to plan, nursing assistants were to provide assistance as needed for bathing, hygiene, grooming and dressing and incontinent episodes. Record review of adl documentation by aides for the month of December 2014 revealed he had 4 showers in a month and one bed bath. Observations on 1/06/15 at 10:38:AM revealed Resident #43 had beard stubbles on his face. Observations on 01/07/15 at 11:11 AM revealed Resident #43 had beard stubbles on his face. Interview with aide #2 on 01/07/2015 at 11:22 AM revealed staff " do everything for him (Resident #43) except eating. " Aide #1 explained he was total care for all of his ADLs. Showers were given by 3-11 shift on Wednesdays and Saturdays. She would do shaves on the days between the resident ' s shower days. When asked if she had provided a shave for Resident #43 she stated she had not. No reason was provided as to why it had not been done. Interview on 1/7/15 at 3:25 PM with nurse #4 who was working on 3-11 revealed she would be notified by the aides if the resident refused a shower and/or shave. Resident #43 would refuse care at times. Interview with aide #5 on 1/7/15 at 4:00 PM revealed she would provide shaves to men on	F 312	months. The QAPI committee will recommend revisions as indicated to sustain substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX 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) COMPLETION DATE
F 312	Continued From page 10 3-11 shift if the day shift did not get them done. No reason was provided as to why Resident #43 had not received a shave the day before. Observations on 01/08/15 at 8:30: AM revealed Resident #43 had a shaven face Interview with aide #2 on 1/8/15 at 9:00 AM revealed she had provided a partial bath, washed his face, hands, underarms and perineum that morning. Aide # 1 explained she had " dressed " him after providing the partial bath. Interview on 01/08/15 at10:54 AM with nurse #1 revealed sometimes 3rd shift gets Resident #43 up. Further interview revealed he did not refuse care that she that she knew about. Interview on 01/08/15 at 2:35 PM with the Director of Nursing revealed she would expect staff to provide shaves for residents when needed and definitely on shower days. If the resident refused, she would expect the staff to keep offering.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		2/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX 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) COMPLETION DATE

F 315 Continued From page 11

This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews and nurse practitioner interview, the facility failed to follow physician ' s order to obtain an in and out catheter for post void residual urine, administration of Ditropan, and urinalysis (UA) and culture and sensitivity (C&S) for 1 of 1 resident (Resident #72).

The findings included:

Resident #72 was admitted to the facility on 5/10/13 with a diagnosis that included; Alzheimer ' s, dementia, hypertension, diabetes Mellitus, gastroesphogeal reflux disorder, and gout. The most recent Minimum Data Set Assessment (MDS) dated 12/4/14 revealed Resident #72 required limited assistance for toileting with the use of one staff person physical assist. The MDS further revealed Resident #72 was occasionally incontinent of urine. Resident #72 was coded as moderately cognitively impaired.

Review of Resident #72 ' s care plan updated 12/12/14 revealed a " problem " of, Elimination " . The " Focus " indicated the resident was at risk for altered bladder elimination. The goal revealed, the resident would be continent and would not develop symptoms of urinary tract infection (UTI). The interventions included, observe and report to medical doctor as needed (PRN) for signs and symptoms of UTI: frequency, urgency, malaise, foul smelling urine, dysuria, fever, pain, supra-pubic pain, hematuria, cloudy urine, altered mental status, loss of appetite, behavioral changes, obtain and monitor

F 315

Resident #72 residual urine was obtained and Ditropan medication administered. The physician was notified on 12/11/14 and dose was changed. There were no adverse outcomes to Resident #72.

Residents currently residing in the facility have a potential to be affected.

Current nursing staff has been in-serviced by the Director of Clinical Services on 1/29/15 and 1/30/15 regarding reviewing and following physician orders as written. Furthermore, the nursing staff was educated on signing off the physician orders as they are completed. Director of Clinical Services/Administrative Nurse will review physician orders for residents requiring in and out catheters, residual urines and medication changes three times a week for four weeks, then two times a week for four weeks, and then weekly for four weeks.

The results of the review will be reported by the Director of Clinical Services/Unit Manager to the Quality Assurance Performance Improvement Committee monthly for 3 months. The QAPI committee will recommend revisions as indicated to sustain substantial compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX 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) COMPLETION DATE
F 315	Continued From page 12	F 315		

lab/diagnostic work as ordered. Report results to medical doctor and follow up as indicated.

Review of Resident #72 ' s physician telephone order dated 10/31/14 indicated, 1) in and out catheter for post void residual urine 2) after the above start Ditropan XL 10 milligrams (used to treat certain bladder and urinary conditions) by mouth daily, UA, C&S culture and sensitivity. No nurse signature was located to identify the order as completed.

Review of Resident #72 ' s physician note dated 10/31/14 stated, Resident #72 himself had no complaints, but his family member states that she is really concerned about his urinary incontinence. The resident had not responded to whatever management strategies have been employed up to this point. The " plan " stated review his medication list with regard to urologic meds and change accordingly. He may be chronically obstructed and require surgical intervention or something along those lines.

Review of Resident #72 ' s physician note dated 11/29/14 stated; resident #72 ' s wife asked that I address his continuing challenges with urinary incontinence. Resident #72 offers no complaints " . The physician note continued with the orders left on 10/31/14 to do a post void residual urine and so forth never got carried out. The note indicated the physician suspected Resident #29 had mixed issues with obstruction and detrusor (muscle of the bladder) instability. The " plan " stated " Resident #72 was already on tamsulosin (medication to improve urination in men), in and out catheter order repeated. Post void residual urine will be measured. Ditropan at half the normal dose will be started empirically and we will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX 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) COMPLETION DATE
F 315	Continued From page 13 see how he does. " Review of Resident #72 ' s Medication Administration Record for the month of November revealed Resident #72 was administered Ditropan on 11/29/14. The medication administration record further dictated; In and out catheter for UA and C&S and post void residual urine. Record residual in nurses note 12/1/14. Review of Resident #72 ' s nurse ' s note dated 12/31/14 revealed a post residual via in and out catheter was obtained. Got back 55cc (cubic centimeters). Urine collection in specimen up to be sent to pharmacy. Cultures obtained were observed to be negative for a urinary tract infection. Interview with Nurse #1 on 1/8/15 at 8:48am revealed when a new order is written it is flagged in the chart for the responsible nurse to review. Once the order is carried out the nurse is to sign the order as proof that it was completed and the order was carried out. The original copy goes in the doctor ' s box and the second copy goes to the pharmacy. Nurse #1 stated she was not aware of the order written 10/31/14. Nurse #1 observed the order written 10/31/14 as not signed by a nurse indicating the order was completed. Interview with the Director of Nursing on 1/8/15 at 8:55am revealed the physician is to flag the order in the resident ' s record so that it is visible to the responsible nurse. The nurse will sign the order as received. A copy of the order would go t the physician and a hard copy would go to the pharmacy. The DON stated the order for Resident #72 written on 10/31/14 was not signed by a nurse. The nurse signing the order would	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX 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) COMPLETION DATE
F 315	Continued From page 14 indicate the order was carried out. The DON further revealed it was her expectation that the physician flag the order and not re-rack the resident ' s chart. She further stated it was her expectation that the nurse sign off on the order, fax to the pharmacy, provide a copy for the physician, follow through on the order, and document the results. Interview with the Nurse Practitioner (NP) on 1/8/15 at 1:23pm revealed she had made the facility aware of the missed order written 10/31/14. The nurse practitioner indicated the U/A and C&S should have been done within 24 hours and order carried out as written.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide contracture management for 1 of 4 sampled residents (Resident #29) who experienced changes in bilateral knee The findings included; Resident #29 was admitted to the facility on	F 318	Resident #29 was evaluated by Physical Therapy and Occupational Therapy on 1/7/15. Physical and Occupational Therapy began treating Resident #29 on 1/7/15 and plans to continue physical therapy 5 times a week and occupational therapy three times a week for 30 days or as long as necessary.	2/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE

F 318 Continued From page 15

4/6/10 with a diagnosis that included Alzheimer ' s disease, hypertension, osteoporosis, senile dementia, muscle weakness, abnormal posture. The annual Minimum Data Set (MDS) assessment dated 11/25/14 revealed Resident #29 had impairments on both side of the lower extremities and required extensive assistance to complete activities of daily living. The MDS further indicated Resident #29 had severely impaired cognition.

Review of Resident #29 care plan dated 11/25/14 revealed no care plan in regards to contracture management or range of motion (ROM).

Review of Resident #29 ' s Initial Physical Therapy Evaluation dated 8/22/13 revealed diagnoses of abnormal posture and contracture of joints (s) of her lower leg. The note indicated Resident #29 ' s right knee extension was -20 degrees and the left knee extension was -30 degrees. The short-term goals indicated Resident #29 would have appropriate wheelchair and cushion to maximize posture, eating/feeding abilities, and environmental awareness. The long term goal was Resident #29 will tolerate new seating and positioning well with no complaints.

Review of Resident #29 ' s Interdisciplinary Therapy Screen dated 9/2/14 stated restorative nursing assistant (NA) reports patient had increased tightness with hip abduction. Requested hip orthotic for positioning.

Interview of Nursing Assistant (NA) #1 on 1/6/15 at 3:35 pm indicate that Resident #29 had contractures of her legs. NA#1 stated Resident # 29 did not utilize any splinting device. NA #1 indicated she did not provide Resident #29 with

F 318

Residents currently residing in the facility have a potential to be affected.

Current nursing staff was in-serviced by the Director of Clinical Services on 1/30/15 regarding the need to observe residents for declines, report the condition, and make a referral to therapy for screening and possible treatment. An assessment of ROM was completed on residents residing in the facility on 1/28/15 through 1/30/15 by the unit manager and a staff nurse. ResidentJ s with a change or deficit were referred to therapy for a screen and possible treatment. ResidentJ s with a change who were not therapy appropriate either had a plan of care developed for ROM with ADL care or were referred to Restorative for development and implementation of a plan of care. When therapy is discontinuing a treatment plan, the therapist will discuss the needs of the resident relative to the need for maintenance or restorative plans. The Restorative Nurse will assess the resident and develop and implement a restorative plan if indicated. If no restorative plan is indicated, the care plan will be updated to reflect the need for maintenance interventions. An assessment of Range of Motion will be completed on all newly admitted residents and quarterly thereafter to identify any changes. The Director of Clinical Services/Administrative Nurse will review the medical record including the care plan for residents that are having Therapy discontinued or experiencing a decline in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 318	Continued From page 16	F 318		

Range of motion.

Interview with NA #2 on 1/7/14 at 8:50 am revealed Resident #29 had contractures in both of her knees. The NA stated Resident #29 legs were tight and stayed in a bent position making it difficult when bathing Resident #29. NA#2 stated that she worked with Resident #29, but had never observed her to wear any splinting device. NA#2 indicated restorative provided range of motion services.

During and Interview and observation with the Therapy Director on 1/8/15 at 9:58am revealed Resident #29 had not been on case load or referred to Therapy since her initial therapy screen of 8/22/13. The Therapy Director indicated residents were referred to therapy when they experience a decline or have worsening of contracture. The observation revealed Resident #29 seated in her Gerri chair. the resident was observed to be seated with her legs in bent position with knees touching. The Therapy Director was observed to attempt to straighten Resident #29 ' s knees and was unable. Following an observation of Resident #29 on 1/8/15 the Therapy Director stated short wave therapy would be needed to loosen up the joint and depending on how fixed the contracture was they would do splinting to prevent the contracture from getting worse. The Therapy Director stated Resident #29 should have been referred to therapy on 9/2/14 when the interdisciplinary Therapy Screen indicated staff observed the resident to have increased tightness with hip abduction. Therapy measured Resident #29 ' s knee extension on 1/8/14 and indicated the resident Left knee extension was -50- degrees and right knee extension was at -40 degrees.

condition for (five) residents per week for (twelves) weeks to ensure that interventions are implemented as indicated to mitigate further decline. The Director of Clinical Services/Administrative Nurse will audit 3 medical records of newly admitted residents to assure the admission ROM assessment was complete for twelve weeks. The Minimum Data Set Coordinator will audit 3 medical records for residents having a quarterly MDS assessment completed for the completion of the quarterly ROM assessment for twelve weeks.

The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Unit Manager to the Quality Assurance Performance Improvement Committee monthly for 6 months. The QAPI committee will recommend revisions as indicated to sustain substantial compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 318	Continued From page 17 Therapy stated the residents contractures had worsened from the last time the resident had been screened 8/22/13. Interview with the Director of Nursing (DON) on 1/8/14 at 4:09 pm revealed it was her expectation that Resident #29 had been referred to Therapy when nursing identified she had increased tightening with range of motion. The DON was unaware of Resident #29 ' s increased tightening with range of motion.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to ensure the side rails were secured to the sides of the bed for one of one sampled residents (Resident # 22). The loose side rails allowed tilting to the right and left; and allowed gaps between the mattress and the side rails. The findings included: Resident # 22 was admitted to facility on 12/2/14 with diagnosis including dementia with behaviors.	F 323	Resident #22 side rails were tightened by the Maintenance Director on 1/6/15. The Director of Clinical Services and Maintenance Director conducted side rails checks on existing side rails in the facility on 1/23/15. Residents currently residing in the facility that have side rails have the potential to be affected. Current nursing staff were in-serviced on identifying potential hazards including	2/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX 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) COMPLETION DATE
F 323	Continued From page 18 The Minimum Data Set (MDS) dated 12/9/14 indicated Resident #22 had mild impairment with short term and long term memory. The MDS assessed Resident #22 had required extensive assistance with bed mobility and transfers by one staff member. Observations on 01/06/15 at 11:00 AM of the side rails on Resident #22 ' s bed revealed the side rails were not secured to the bed. Resident #22 was lying on his back in the bed during the observation. The side rails would move to the right and left of the center of the side rail. There was approximately 3 inches between the side rail and the mattress on the resident's left side and 2.5 inches on the resident's right side. Interview with Resident #22 during the observations on 1/6/15 at 11:00 AM revealed he used the side rails to assist when getting out of bed. Observations on 01/07/15 at 11:20 AM revealed the side rails on Resident #22 ' s bed were unchanged. On 01/07/15 at 1:13 PM in an interview with the Maintenance Director it was explained he checked the side rails on the beds every quarter. During the interview the side rails were checked by the maintenance director and found to be " loose. " The resident ' s alarm box and two boxes of tissues were removed from the gap on the left side of the bed prior to correcting the loose rail. The Maintenance Director obtained a large wrench and tightened the knob in the center of the side rail. Once it was tightened, there was no movement in the side rail and no gap between the mattress and side rail. The maintenance	F 323	identification of side rails that are loose, rails that are tilting to the left/right, gaps between side rails and mattresses, and the use of the maintenance request log. The Maintenance Director and Director of Clinical Services/Administrative Nurse will complete rounds and monitor side rails for loose rails, left/right tilt of the rail, or excessive gaps between the side rail and the mattress three times a week for four week, then two times a week for four weeks, then weekly for four weeks. Results of the rounds will be discussed in the Quality Assurance Performance Improvement Committee meeting monthly for three months. The QAPI committee will recommend revisions to the plan to sustain substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 323	Continued From page 19 director stated he was not informed by staff it (side rail) was loose. He explained the method of communicating maintenance requests was by the "Maintenance Requests" flow sheet located on a clipboard at the nurse's station. Upon review with the Maintenance Director the loose side rail had not been reported on the flow sheet. Interview with the Maintenance Director on 01/07/15 at 1:41 PM revealed the side rails were last checked in October 2014. Interview with floor nurse #1 on 01/08/15 at 10:08 AM revealed she had not noticed the side rails for Resident #22 were loose and a wide space between the mattress and side rail. She stated the " old rails " would become loose at times. Interview on 01/08/15 at 10:32 AM with the Administrator revealed he would expect as rounds are made, it (loose side rail) should have been noted and reported.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		2/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 329	Continued From page 20 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assess for abnormal involuntary movements for one of five residents receiving an antipsychotic medication. Resident #22. The findings include: Resident # 22 was admitted to facility on 12/2/14 with diagnosis including dementia with behaviors. Review of the admission orders dated 12/8/14 revealed an order for Haldol (a psychotic medication) 2 milligrams (mg) to be given twice a day. A physician ' s order dated 12/8/14 to reduce the dose of Haldol from 2 mg to 1.5 mg twice a day. The Minimum Data Set (MDS) dated 12/9/14, admission assessment, indicated Resident #22 had mild impairment with short term and long term memory. The MDS assessed Resident #22 as having a behavior of wandering that occurred 1-3 days and moods included feeling tired or		For Resident # 22, the pharmacy conducted a medication regimen review on 1 /21/15. For Resident #22, documentation of an assessment for abnormal involuntary movements was completed on 1/12/15 by RN Unit Manager. Residents residing in the facility that have physicianJ s orders for Antipsychotic medications have the potential to be affected. The Pharmacist Consultant conducted a medication regimen review for residents currently residing in the facility on 1/21/15. Re-education has been provided to currently employed Licensed Nurses by the Director of Clinical Services/Administrative Nurse regarding the regulation for un-necessary medications and assessment of abnormal involuntary movements. Quality Improvement monitoring will be conducted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 329	Continued From page 21 having little energy. There were no behaviors of physical or verbal inappropriate behaviors with others assessed on the MDS. The Care Area Assessments dated 12/11/14 indicated Resident #22 had problems with cognitive loss/dementia and a psychotropic medication was being administered. A decision was made to proceed to care plan for these two areas. The care plan dated 12/9/14 included problems of behaviors and psychotropic drug use. Interventions/approaches for the target behaviors included medications as ordered, activities, redirection, and positive feedback and explain procedures first. The nursing staff were to assess for side effects of medications. Review of Resident #22 ' s medical record revealed an AIMs assessment was not completed since the resident ' s admission to the facility on 12/02/14. On 1/07/2015 at 1:38 PM an interview was conducted with Nurse #1. This nurse explained the AIMs (Abnormal Involuntary Movement) assessment would be done on admission if the resident was on psychotropic medications. The assessment would be completed by the floor nurse. Nurse #1 reviewed the chart, and did not see an AIMs assessment in the chart. On 01/07/2015 at 1:42 PM Nurse #2 was interviewed. Nurse #2 explained the floor nurses would complete an AIMs assessment. Resident #22 received Haldol due to a diagnosis of depressive disorder. His behaviors included verbal outbursts, wanting to leave the facility and	F 329	via the Director of Clinical Services/Administrative Nurse to ensure that abnormal involuntary movement assessments and documentation is completed. The QI monitoring will be conducted by the Director of Clinical Services/Administrative Nurse for (five) residents three times per week for four weeks, then two times per week for four weeks, then weekly for four weeks. Results of the Quality Improvement Monitoring will be discussed in the Quality Assurance Performance Improvement Committee Meeting monthly for three months. The QAPI committee will recommend revisions to the plan to sustain substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 329	Continued From page 22 upset/arguing with his wife when she visits. Interview on 01/07/2015 at 2:34PM with the Director of Nursing revealed she had no irregularities for Resident #22 reported by the consulting pharmacist. The pharmacist ' s report was completed in December 2014. She was not aware an AIMs test had not been completed on admission for Resident #22. Interview with the consulting pharmacist on 01/08/2015 at 9:44 AM revealed she would typically look for the AIMs or DISCUS (Dyskinesia Identification Condensed Users Scale) test to be done. The facility had within 30 days to do the AIMs when a resident received an antipsychotic. The pharmacist explained she would review the December information when the January visit was made. Any recommendations would be made to the Director of Nursing in January 2015. Interview with the Director of Nursing on 01/08/2015 at 10:01 AM revealed her expectations of the nursing staff would be to complete the AIMs on admission.	F 329		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520		2/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	**333 EAST LEE STREET YADKINVILLE, NC 27055**

(X4) ID PREFIX 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) COMPLETION DATE
F 520	Continued From page 23 issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		
	A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.			
	Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.			
	This REQUIREMENT is not met as evidenced by:			
	Based on staff interviews and record review the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these procedures that the committee put into place in October 2014. This was a cited deficiency during a complaint investigation on September 2014. The deficiency was in the area of unnecessary drugs.		Quality Assurance Performance Improvement Committee meeting was held on 1/22/15. A review of the residents receiving antipsychotic medications was completed as well as review of AIMS completed for those residents with physicianJ s orders for antipsychotic medications.	
	Findings included:		Residents currently residing in the facility with orders for antipsychotic medications have a potential to be affected.	
	This tag is cross referenced to F329-D. Based on record review and staff interviews the facility failed to assess for abnormal involuntary movements for 1 of 5 residents receiving an antipsychotic medication. (Resident #22)		Re-education has been conducted with the Executive Director and Director of Clinical Services by a member of the Regional Management Team regarding the regulations for F520 and ongoing Quality Assurance Performance Improvement. The education will also include ensuring that items previously	
	The facility ' s plan implemented on October 2014 indicated that Quality Improvement monitoring to ensure that non- pharmaceutical interventions were attempted and rationale for use and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX 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) COMPLETION DATE
F 520	Continued From page 24	F 520		

effectiveness of medications are documented.

The policy titled: Quarterly Psychotropic Medication Review obtained from the Director of Nurses on 1/8/15 at 11:40 AM revealed under Procedure: #4- The Psychotropic Medication Review is used to assess the resident ' s response to the medication and analyze the presence of any side effects resulting from the medication. #5- As means to facilitate the review as well as document the findings, the Quarterly Psychotropic medication Review must be completed.

An interview with the Administrator on 1/8/15 at 4:00 PM revealed that the Psychotropic Committee review is part of the Quality Assurance Committee meeting. The residents on psychotropic medications are reviewed weekly. The committee members consist of the pharmacist if available, the director of nurses, the unit manager and any other nurse as needed. The weekly reviews are brought to the monthly Quality Assurance committee meeting for review.

The Director of Nurses indicated during an interview on 1/8/15 at 4:30 PM that the administrator, director of nurses, staff development, social worker, (MDS) Minimum Data Set nurse and consulting pharmacist when needed, meet weekly to review gradual dose reduction for psychotropic medications. The review includes new admissions and it is the review for psychotropic medications that is done weekly. The areas that are reviewed are gradual dose reductions, target behaviors, diagnosis and (AIMS) abnormal involuntary movement symptoms. The results of the weekly meeting is reviewed in the monthly Quality Assurance

taken to the QAPI committee are continued in the QAPI committee until corrected including residents with physicianJ s orders for antipsychotic medications and completion of Abnormal Involuntary Movement Assessments. Quality Improvement monitoring will be conducted by the Executive Director/Director of Clinical Services to ensure that areas identified to require correction continue to be taken to QAPI each month for evaluation until the identified area is resolved. Quality Improvement monitoring will be conducted via the Director of Clinical Services/Administrative Nurse to ensure that abnormal involuntary movement assessments and documentation is completed. The QI monitoring will be conducted by the Director of Clinical Services/Administrative Nurse for (five) residents three times per week for four weeks, then two times per week for four weeks, then weekly for four weeks.

Results of the Quality Improvement Monitoring will be discussed in the Quality Assurance Performance Improvement Committee Meeting monthly for three months. The QAPI committee will recommend revisions to the plan to sustain substantial compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX 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) COMPLETION DATE
F 520	Continued From page 25 meeting. The director of nurses further indicated that the AIMS are completed on admission and reviewed weekly and she does not know why Resident #22 was not assessed for abnormal involuntary movements.	F 520		