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

PRINTED: 04/20/2022 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER WILLOWBROOK REHABILITATION AND CARE CENTER SIRREIT ADDRESS, CITY, STATE, ZIP CODE 33S EAST LEE STREET YADKINVILE, NC 27055 BOAK REGULATORY OR LEE IDENTIFYING INFORMATION) EXCHANGES VALUE CORRECTION REGULATORY OR LEE IDENTIFYING INFORMATION) E 000 Initial Comments An unannounced recertification survey was conducted on 31/4/22 through 31/7/22. The facility was found in complianare with the requirement CFR 483 73. Emergency Preparedness. Event ID #1F5811. F 577 Right to Survey Results/Advocate Agency Info S483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility, and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. \$483.10(g)(11) The facility must- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility, and (iii) Receive information from agencies acting as client advocates, and plan presentatives of residents, the results of the most recent survey of the facility, and (ii) Receive information from agencies acting as client advocates, and plan presentatives of residents, the results of the most recent survey of the facility, and (ii) Rocate information from agencies acting as client advocates, and plan presentatives of residents, and family members and legal representatives of residents, the results of the most recent survey of the facility, and plan for correction in effect with respect to the facility, available for any individual to review upon request, and (iii) Post notice of the availability during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request, and any plan of correction in effect with respect to the facility and the availability information about complianants or residents. This REQUIREMENT is not met as evidenced by. Based on observation	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST are PRECEDED BY TILL TAG CROSS-REPERENCE OF TILL TAG CR			345466	B. WING		03/17/2022	
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conducted on 3/14/22 through 3/17/22. The facility was found in compliance with the requirement CFR 483-73, Emergency Preparedness, Event ID #1F5811. F 577 Rght to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility, and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility, that are prominent and accessible to the public. (iv) The facility that are prominent and accessible to the public. (iv) The facility sall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to post the availability	E 000	Initial Comments		E 000			
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		(i) Post in a place reand family members residents, the results the facility. (ii) Have reports with certifications, and corespecting the facility years, and any plan respect to the facility to review upon reque (iii) Post notice of the areas of the facility thaccessible to the pull (iv) The facility shall information about contains REQUIREMEN by: Based on observations.	adily accessible to residents, and legal representatives of s of the most recent survey of a respect to any surveys, amplaint investigations made y during the 3 preceding of correction in effect with a available for any individual est; and e availability of such reports in that are prominent and colic. not make available identifying mplainants or residents. T is not met as evidenced		1 '	io	
	ADODATE					000 8477	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed 03/29/2022

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345466	B. WING			3/17/2022	
NAME OF P	ROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP COL	•	<u> </u>	
				333 EAST LEE STREET			
WILLOWB	ROOK REHABILITATIO	ON AND CARE CENTER		YADKINVILLE, NC 27055			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 577	Continued From pag	ge 1	F 5	77			
	of the facility's surve	y results. This practice had					
		t all residents in the facility.		2) The Activities Director edu	cated		
				residents regarding the locati	ion and		
	Findings included:			availability of recent survey rethe monthly resident council			
	During a tour of the	facility including the secured		04/01/2022.	•		
	unit on 03/17/22 at 9	9:06 AM an observation was					
	made that survey results were not posted. There			3) The Vice President of Ope	rations		
	was no notice posted in the facility regarding the			educated the Executive Direct	ctor on		
	availability and locat	ion of recent survey results.		03/17/2022 on posting notice availability and location of red			
	On 03/17/22 at 9:10 AM Resident #19, the			results to inform residents, fa	milies and		
	Resident Council President revealed she had no			staff. On 03/28/2022, the Exe	ecutive		
	knowledge of the location of the survey results			Director posted signs at the r			
	notebook. She stated she was not aware where			station and on the secured u	_		
		nd had not seen any signage		the location of the survey res			
	that directed residen	its to their location.		posted in the front lobby outs			
				Executive Directors office. The			
		AM an interview with a Nurse		Director, Activities Director, S			
	#1 working on the secured unit revealed there			Director, and or Admissions I			
	was no survey results notebook on the secured			perform Quality Improvemen	-		
	unit. She stated the results were up front. She			through resident interviews e	-		
	further stated if family asked about the results, she would take them up front and find them			residents are aware of the lo			
	She would take then	rup iront and find them		availability of the recent survinterviewing 3 residents 1 times			
	On 03/17/22 at 0:20	AM in an interview with a		4 weeks then 1 times a mont	•		
		ding the location of the		months. The interdisciplinary			
	_	stated "I would assume they		ensure signs are posted rega			
		She indicated if family asked		availability and location of red			
	•	vould locate them and inform		results through observation.	•		
	the family of their loo			educated in orientation.			
		AM in an interview with the		4) On 3/29/2022, the Executi			
	•	indicated the results were		will present the Plan of Corre			
	posted at the front.			Quality Assurance Performance			
				Improvement Committee and			
		AM during an interview with		Quality Improvement Monitor	•		
		e pointed at the file holder		observed by the Executive D			
	outside her door who	ere the survey results book		Interdisciplinary team. The re	sults of the		

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		345466	B. WING _			03/17/2022	
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK REHABILITATION AND CARE CENTER			•	STREET ADDRESS, CITY, STATE, ZIP COD 333 EAST LEE STREET YADKINVILLE, NC 27055	E		
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F 577	on the file holder that survey results noteboresults were not posted facility. She indicated were no signs posted indicating the location. On 03/17/22 at 11:40 with the Administrator signage to be posted the lobby indicating the results. She further stresults and the location discussed in Residen.	atted there used to be a sign indicated it contained the ok. She further stated the ed anywhere else in the to her knowledge there anywhere else in the facility of the survey results. AM in a follow-up interview she stated she expected at all nurse stations and in the location of the survey on of survey results to be to Council and that all newly there to be made aware of	F 5	Quality Improvement Monitori reported to the Quality Assura Performance Improvement Counties the Executive Director and or Clinical Services to ensure conscisived and maintained, monitoring and three month and then quarter quarters. Quality Monitoring sometimes may be modified based on quarter formance Improcommittee members consist limited to the Executive Director of Clinical Services, Nursing Sometical Director, Social Services Activities Director, Maintenan and Minimum Data Assessment and at one direct care staff.	ance committee by Director of compliance is conthly for dy for two cocheduled cality lity covement of but not tor, Director Supervisor, cee Director ce Director		