PRINTED: 06/09/2025 FORM APPROVED

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT SC CTR AT TRYON ESTATE (X4) ID PREVIX (EACH DEPTICIENCY) STATE BEPT OF DEFCIENCIES, TAY OR LIST INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION ACTION SHOULD BE REGULATION OR LIST IDENTIFYING INFORMATION) L 000 INITIAL COMMENTS A paper follow up was conducted on 06/05/25 and the facility is back into complaince effective 05/11/25.			(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 619 LAUREL LAKE DRIVE COLUMBUS, NC 28722 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A paper follow up was conducted on 06/05/25 and the facility is back into complaince effective STREET ADDRESS, CITY, STATE, ZIP CODE 619 LAUREL LAKE DRIVE COLUMBUS, NC 28722 ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A paper follow up was conducted on 06/05/25 and the facility is back into complaince effective	NUMBER				B WING				
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Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE