STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345466**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Rehabilitation and Care	**333 East Lee Street , Yadkinville, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/09/25 through 9/12/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D 5A64 H1.	E0000		
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 9/09/25 through 9/12/25. Event ID# 1D5A64-H1. The following intakes were investigated 865007, 865008, 865011, 865021, 2612464, and 2605949. 16 of 16 complaint allegations did not result in deficiency.	F0000		
F0640 SS = A	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility	F0640		

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345466**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/12/2025**
NAME OF PROVIDER OR SUPPLIER **Willowbrook Rehabilitation and Care**	STREET ADDRESS, CITY, STATE, ZIP CODE **333 East Lee Street , Yadkinville, North Carolina, 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
F0640 SS = A	Continued from page 1 must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment within 14 days of the discharge date for 1 of 2 residents reviewed for resident assessment (Resident #14). The findings included: Resident #14 was admitted to the facility on 3/14/25. Review of Resident #14's medical record revealed she was discharged on 3/28/25.	F0640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Rehabilitation and Care	**333 East Lee Street , Yadkinville, North Carolina, 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
F0640 SS = A	Continued from page 2 Review of Resident #14's medical record revealed the last completed MDS assessment was a comprehensive assessment dated 3/21/25. There was no discharge assessment completed or transmitted. During an interview with the MDS Coordinator on 09/11/25 at 10:28 AM while viewing the medical records she stated the resident MDS had been sitting in their old system, and she failed to transmit the Discharge Return Not Anticipated MDS for the resident. In an interview on 9/12/25 at 10:19 AM the Administrator stated she expected that the discharge MDS assessment would be completed and transmitted according to guidelines.	F0640		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff interviews, the facility failed to ensure 1 of 1 sampled resident (Resident #76) attended his doctor appointment when Resident #76 missed a scheduled orthopedic appointment on 9/12/24 to have stitches removed due to facility failure to transcribe the order resulting in a missed doctor appointment. The findings included: Resident #76 was admitted to the facility on 9/2/24 with diagnosis including displaced subtrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing and anxiety. Resident # was discharged from the facility on 9/20/24. During an interview with Unit Manager #1 on 9/11/25 at 12:03 p.m. she revealed that Resident #76 missed his appointment to have his stiches removed on 9/12/24. She stated the DON received telephone orders on 9/6/24 but did not document the information. She further stated that as soon as they noticed the error on 9/19/24, they made Resident #76 an appointment. She stated that she did a wound assessment on Resident #76 on 9/19/24 and	F0658	"Past Noncompliance - no plan of correction required"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Rehabilitation and Care	333 East Lee Street , Yadkinville, North Carolina, 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
F0658 SS = D	Continued from page 3 that the wound did not get infected and Resident #76 did not experience any harm. In an interview with the Director of Nursing (DON) on 9/11/25 at 3:44 p.m. she stated that Resident #76 missed an appointment for his stiches to be removed because she forgot to transcribe the order from Resident #76's doctor on 9/6/24. She stated she received the telephone order 9/6/24 to remove the stitches but did not transcribe it to the Treatment Administration Record (TAR) leading to Resident #76 missing his appointment on 9/12/24. The DON stated that she was responsible for the error of not transcribing the order and communicating to the nursing staff. She stated that when the error was discovered she contacted the doctor's office, and the resident was seen on 9/19/24. In a telephone interview with the prior Administrator on 9/12/25 at 9:17 a.m. She revealed that DON's failure to transcribe a telephone order for Resident #76 on 9/6/24 was responsible for Resident #76's missing his appointment on 9/12/24. The prior Administrator stated that the facility discovered the missed appointment on 9/19/24 when the doctor's office called the facility. She stated that the DON secured an appointment for Resident #76 to be seen on the same date. The prior Administrator further stated that lack of documenting in the TAR caused the error. She stated that a plan of correction was immediately implemented when the error was identified to ensure residents orders and appointments are transcribed correctly. The facility provided the following corrective action plan: •Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/19/24 Resident #76 went to his orthopedic appointment to have staples removed. Unit manager assessed the wound to ensure no signs and symptoms of infection ae present. Director of Nursing (DON) failed to put wound order into Point Click Care (PCC) causing transcript error. The admitting nurse failed to obtain wound care orders when doing initial assessment. -The facility recognizes that all residents who have wounds have the potential to be affected by the noncompliance failure to transcribe orders per the physician and not providing transportation to scheduled appointments for follow-up needs.	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Rehabilitation and Care	**333 East Lee Street , Yadkinville, North Carolina, 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
F0658 SS = D	Continued from page 4 On 9/19/24 an assessment and review of Resident #76's by the Unit manager found no evidence of trauma or infection. Or deterioration of the surgical wound. On 9/19/24 the Assistant Director of Nursing (ADON) re-educated nurses on contacting the Physician to obtain any wound orders on admission as indicated. On 9/19/24 the Regional Director of Nursing re-educated the DON on ensuring that when taking orders via telephone the orders are placed into PCC, and they are on the residents' Treatment record as indicated to prevent transcription errors. On 9/19/24, Regional Director of Clinical services completed a root cause analysis regarding the noncompliance of transcribing wound orders. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 9/19/24 all residents are identified as having the potential to be affected for those who have wounds and follow up appointments. A quality review of 100% of current residents with wounds and scheduled appointments was audited by the Unit managers to ensure all residents who have wounds have orders in pace per physician and any follow-up appointments have transportation scheduled. On 9/19/24 the Unit managers re-educated nurses that when doing the initial skin assessments on all new admissions or readmissions that if there is any wounds to obtain an order for treatment and to place on the treatment record to ensure proper treatment is in place per physician orders and to place all needed follow up appointments in the transportation box to bring to bring to clinical to ensure all appointments are scheduled and transportation is set up accordingly. • Address what measures were put in place to ensure the deficient practice will not recur: On 9/19/24 the nursing managers re-educated all nurses when admitting a patient to ensure proper treatment is in place per physician order. -Newly hired nurses will be educated during the orientation on obtaining orders and placing them into PCC for any resident who requires treatment for any wound according to physician orders and to ensure communication to physician and Unit managers related to follow up appointments are scheduled with proper	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Rehabilitation and Care	**333 East Lee Street , Yadkinville, North Carolina, 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
F0658 SS = D	Continued from page 5 transportation. -A quality review was conducted by unit managers on 9/19/24 to ensure all residents with wounds had treatment in place as indicated and all residents who have appointments scheduled have transportation scheduled. -the Executive Director conveyed an ADHOC Quality Assurance Performance Improvement Committee was to determine the root cause analysis, formulate and approve a plan of correction for the deficient practice to include education, policies and procedures and quality improvement monitoring. The facility will conduct quality improvement audits to ensure compliance with the deficient practice through audits and education. •Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained. On 9/19/24, when the deficient practice was identified, the center's Executive Director (ED) conveyed an ADHOC Quality Assurance Improvement meeting to determine the root cause analysis of the deficient practice, formulate and approve a plan of correction to include education, policies and procedures and quality improvement monitoring beginning 9/19/24. The facility will conduct quality improvement audits to ensure compliance with the deficient practice through audits and education. On 9/23/24 the unit managers and DON began using the quality improvement data collection form to monitor all admissions and re-admissions skin assessments to ensure treatment orders are obtained and put into the OCC and any appointments are scheduled 3 times a week x 4 weeks in clinical, then 2 times a week x 4 weeks in clinical, then weekly in clinical x 4 weeks. Beginning 9/19/24 the DON and Nurse Managers conducted Quality improvement monitoring on all admissions and re-admissions to ensure all residents who need treatment for wounds are being treated accordingly and all residents who require appointments are attending all scheduled appointments in clinical meetings 3 days a week x 4 weeks, then 2 times a week x4 weeks, then weekly for 4 weeks to ensure compliance. The Executive Director will report the results of the monitoring to the QAPI committee for review and recommendations for the period of the monitoring period or as is amended by the committee.	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Rehabilitation and Care	333 East Lee Street , Yadkinville, North Carolina, 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
F0658 SS = D	Continued from page 6 Compliance/completion date for the corrective action plan: 9/20/24 Validation of the corrective action plan was completed on 9/12/25 by the following: A review was completed of the signature pages for the in-service training for nursing staff on correctly transcribing doctor orders. Interview of nursing staff showed they received in-service training regarding transcribing doctor orders correctly. A review of the audit tool used by the facility to monitor performance was found to be completed according to the plan of correction. The monitoring documentation showed the audits were completed on 12/12/24. The facility's corrective action plan completion date of 9/20/24 was validated.	F0658		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 31 medication administration opportunities resulting in a medication error rate 6.45% for 2 of 6 residents observed during medication pass (Resident #3 and Resident #41). The findings included: 1.Resident #3 was admitted to the facility on 7/3/25 with diagnoses that included glaucoma. A review of Resident #3's active physician orders dated 7/3/25 included a current order for Dorzolamide HCL-Timolol Maleate Ophthalmic Solution 2-0.5% (a combination medication used to lower intraocular	F0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345466**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Rehabilitation and Care	**333 East Lee Street , Yadkinville, North Carolina, 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
F0759 SS = D	Continued from page 7 pressure in patients with open-angle glaucoma) one (1) drop to right eye twice a day. This medication was not administered to Resident #3 as ordered on 9/11/25. On 9/11/25 at 9:15 AM, Nurse #1 was observed as he prepared and administered 8 oral medications to Resident #3. Nurse #1 reported Resident #3's Dorzolamide HCL-Timolol Maleate Ophthalmic Solution 2-0.5% was not available on the medication cart for administration. Nurse #1 stated he would reach out to the pharmacy to reorder the medication. During an interview with Nurse #1 on 9/11/25 at 9:20 AM, he indicated he was unable to locate the medication in the medication cart. Nurse #1 was unable to indicate why the medication was not available. He stated he would follow up with the pharmacy to see if the medication could be sent with the next medication delivery. An interview was conducted with the Director of Nursing (DON)on 9/12/25 at 1:00 PM. The DON stated if a medication was not available for administration, the nurse should go to the Omnicell to see if the medication was there. The DON stated she expected that the nurse would notify the provider if a medication was missing and follow further instructions for the missed dose provided by the provider. 2. A review of the manufacturer's instructions on the preparation for use of the Budesonide-Formoterol Fumarate Inhalation Aerosol inhaler was conducted. The instructions read, in part: Shake your Budesonide-Formoterol Fumarate Inhalation Aerosol inhaler well for 5 seconds right before each use. Remove the mouthpiece cover. Hold the Budesonide-Formoterol Fumarate Inhalation Aerosol inhaler up to your mouth and close your lips around it. Breathe in (inhale) deeply and slowly through your mouth. Press down firmly and fully on the top of the canister to release the medication. Shake the Budesonide-Formoterol Fumarate Inhalation Aerosol inhaler again for 5 seconds and repeat the above steps. Resident #41 was admitted to the facility on 6/26/25 with diagnoses that included chronic obstructive pulmonary disease (COPD). A review of Resident #41's active physician orders dated 6/26/25 included a current order for Budesonide-Formoterol Fumarate Inhalation Aerosol 80-4.5 MCG/AC inhale 2 puffs every 12 hours. Budesonide-Formoterol Fumarate Inhalation Aerosol is an inhaled medication containing a combination of	F0759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Rehabilitation and Care	**333 East Lee Street , Yadkinville, North Carolina, 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
F0759 SS = D	Continued from page 8 budesonide and formoterol use for the management of COPD. On 9/12/25 at 8:50 AM, Nurse #2 was observed as she administered Budesonide-Formoterol Fumarate Inhalation Aerosol 80-4.5 MCG/AC to Resident #41. Nurse #2 retrieved the inhaler from the box and shook the inhaler for 5 seconds. Nurse #2 removed the mouthpiece and administered 2 puffs of medication without shaking the inhaler between puffs. An interview conducted with Nurse #2 on 9/12/25 at 8:57 AM revealed she had forgotten to wait and shake the inhaler between inhalations. The nurse stated she realized she should have waited and shook the inhaler between doses but just forgot. An interview was conducted with the Director of Nursing (DON) on 9/12/25 at 1:00 PM. The DON stated some of the newer combination inhalers did not require the nurse to wait 3 to 5 minutes between each puff of medication. The DON retrieved the manufacturer's instructions which stated in part the inhaler was to be shaken for 5 seconds, and a repeat inhalation administered. The DON stated she expected that the nurse would follow the manufacturer's instructions when administering inhalers. An interview was conducted with the Administrator on 9/12/25 at 1:49 PM. The Administrator stated she expected medications would be administered as ordered by the provider and manufacturer's instructions would be followed.	F0759		