

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
--	---	--	---

NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen	STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105
---	---

(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
--------------------	--	---------------	---	----------------------

L0000	<p>INITIAL COMMENTS</p> <p>A complaint investigation was conducted on 12/30/25 through 12/31/25. Additional information was gathered offsite through 01/05/26, therefore the exit date was changed to 01/05/26. The following intake was investigated: 2688222. Event ID: 1DF77C-H1.</p> <p>1 of 1 allegation resulted in deficiency.</p> <p>A Type A2 past corrected violation was identified at 10 A NCAC 13 D .2208 (e)(2)</p> <p>The Type A2 violation began on 12/05/25 and was removed on 12/10/25.</p>	L0000		01/10/2026
L0039	<p>SAFETY</p> <p>CFR(s): .2208(E)</p> <p>10A-13D.2208 (e) The facility shall ensure that:</p> <p>(1) the patients' environment remains as free of accident hazards as possible; and</p> <p>(2) each patient receives adequate supervision and assistance to prevent accidents.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, online global position service (GPS) data, online weather source, record review, and family, staff, and Nurse Practitioner interviews, the facility failed to provide necessary supervision for Resident #1, who was identified as severely cognitively impaired, had a diagnosis of Alzheimer's disease and dementia, had exit seeking behavior, and was identified</p>	L0039	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusion outlined in the statement of deficiencies. This Plan of Correction is prepared solely as a matter of compliance with the State law.</p> <p>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>On 12/05/25, Resident #1 exited the Cedar Ridge neighborhood (a secured memory care unit). The resident lifted the cover over the emergency door release button (screamer alarm), but the alarm did not sound. She then pressed the door release button, which unlocked the door and allowed her to leave the secure neighborhood. The resident's wander guard pendant activated the wander guard system, which alarmed at 3:22 p.m. The alarm was disarmed at 3:24 p.m. by an unidentified staff member.</p> <p>The resident was located on 12/05/25 outside the back of WillowBrooke Court near the exit gate at 3:34 p.m. by Nurse Aide (NA) #1. NA #1 notified the Nursing Home Administrator (NHA) via telephone and assisted the resident into her car. NA #1 then escorted the resident back to WillowBrooke Court at 3:43 p.m.</p>	01/10/2026

Office of Primary Care and Health Systems Management

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

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 1 as at high risk for elopement, from exiting the facility without supervision and staff knowledge. On Friday, 12/05/25, at 3:22 PM, Resident #1 had an unsupervised exit out of the facility through the back door of the memory care unit, without staff supervision or staff knowledge. Resident #1 was found alone on an uneven wooded gravel walking trail approximately 1,087 feet from original exit point. In the suspected path, Resident #1 ambulated on the sidewalk behind the facility, down a set of 23 concrete stairs, past a loading dock, through the parking lot, and onto the gravel walking trail. Resident #1 was discovered by a staff near the facility exit gate and approximately 75 feet from a 3-lane heavily traveled road with a posted speed limit of 35 miles per hour (MPH). Resident #1 was returned to the building with staff assistance at 3:42 PM. Due to the resident being unsupervised, having severe cognitive impairment, and being in an area with multiple hazards, there was a high likelihood that Resident #1 was at risk for serious harm, serious injury/impairment, or death. The deficient practice was found for 1 of 3 residents reviewed for safety (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was initially admitted to the secure memory care unit on 06/02/25 from the community with a readmission after hospitalization on 07/02/25. Resident #1's diagnoses included Alzheimer's disease, unspecified dementia with aggression, cerebrovascular disease (a condition affecting the brain's blood vessels), and non-Alzheimer's dementia.</p> <p>During a telephone interview on 12/31/25 at 3:42 PM Family Member #1 stated Resident #1 had Alzheimer's disease and was admitted to the memory care unit at the facility due to history of attempting to elope at home.</p> <p>A review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated 09/09/25 indicated Resident #1 had severe cognitive impairment, ambulated independently, had sustained one fall with no injury since previous MDS assessment, exhibited exit seeking behavior 4 to 6 days during the 7-day review period, and utilized a wander alert device daily.</p> <p>A review of Resident #1's care plan revealed the following areas of focus: A care plan initiated 06/02/25 had the area of focus for Resident #1's risk of wandering and the use of a wander alert device. The stated goal for this care plan was that Resident #1 would have no episodes of wandering. Interventions included wearing a wander alert device and checking the</p>	L0039	<p>Continued from page 1</p> <p>On 12/05/25, the charge nurse evaluated Resident #1 for injury, pain, or discomfort; no adverse findings were noted.</p> <p>On 12/05/25, a headcount of Cedar Ridge residents was conducted by nursing staff, and it was verified that all residents were present in the neighborhood.</p> <p>On 12/05/25, Resident #1 was placed on 30-minute checks by the NHA/Director of Nursing (DON). These checks are currently ongoing. On 12/06/25, an additional staff member was added to the Cedar Ridge neighborhood to assist with resident oversight. The NHA/DON directed that an additional NA be assigned to the neighborhood; this measure remained in place until 12/17/25.</p> <p>On 12/05/25, the Maintenance Foreman assessed the wander guard system's alarm panels and exit doors. He verified that the alarm panels and exit doors were functioning properly. The neighborhood has eight exit doors, all equipped with wander guard alarm panels. The Maintenance Foreman tested the system using a wander guard pendant to confirm that the alarm panel activated when the pendant crossed the threshold. He also confirmed that the door did not unlock when the pendant was near the exit door. When the emergency release button (screamer alarm) is activated, it unlocks the door; however, when the pendant crosses the threshold, the wander guard alarm will sound.</p> <p>On 12/05/25, the Maintenance Foreman assessed the lift covers for the emergency release button. The lift cover is a flip-style shield that covers the emergency door release button. Once lifted, a "screamer alarm" sounds as a deterrent. Batteries for screamer alarms were replaced as needed.</p> <p>On 12/05/25, the nurse supervisor notified the Nurse Practitioner and the family that Resident #1 had eloped from the facility.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>On 12/05/25, physician orders for current residents were reviewed by the charge nurse to determine who wore a wander guard. The charge nurse then verified the function and placement of each wander guard pendant. This was verified using a handheld device called the Code Alert system, which lights up green to confirm</p>	

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 2 placement and function of wander alert device regularly. A care plan initiated 06/13/25 had an area of focus for Resident #1's history of attempted elopements and poor safety awareness. The stated goal was that Resident #1 would remain in a safe, supervised environment. Interventions included provide Resident #1 with distractions from wandering behavior, identify patterns of wandering, provide engaging activities, and assess Resident #1 for fall risk. A care plan initiated 07/04/25 had an area of focus for Resident #1's risk of falls due to confusion, and poor safety awareness resulting from dementia. The stated goal was that Resident #1 would not sustain a fall with injury. Interventions included monitoring the environment for safety concerns (spills, adequate lighting, personal items within reach, etc.), anticipate Resident #1's needs, educate caregivers on safety and how to respond to a fall, and follow facility fall protocols.</p> <p>A review of Resident #1's physician orders revealed an active order dated 07/02/25 for wander guard bracelet to left wrist, check for placement every shift.</p> <p>A review of an elopement risk assessment completed by the Unit Manager dated 12/04/25, indicated Resident #1 ambulated independently, demonstrated a history of wandering behavior, frequently made statements about leaving, displayed exit seeking behavior, had a diagnosis of dementia, had a care plan for wandering behavior, and utilized a wander alert device. Resident #1 scored 28 which placed her in the high-risk category for elopement.</p> <p>A review of a fall risk evaluation completed by the Unit Manager dated 12/04/25, indicated Resident #1 had intermittent confusion, had a history of 1 to 2 falls within the last 3 months, and received 1 to 2 medications which could cause lethargy and/or confusion. Resident #1 was assessed to have a high risk for falls.</p> <p>A progress note dated 12/05/25 at 3:30 PM, written by Nurse #2 revealed Resident #1 was observed outside and brought back by an employee. Resident #1 had no obvious injury noted but was agitated and refused a full skin assessment.</p> <p>Observations of the secure memory care unit were conducted on 12/30/25 at 9:41 AM and 12/30/25 at 11:36 AM. The secure memory care unit was located on the ground floor of the facility and was 1 of 2 units located on the ground floor. Entry to the secure memory unit required a code to be entered into a keypad located on the wall next to the entry door. A doorbell</p>	L0039	<p>Continued from page 2 that the pendant is active.</p> <p>On 12/06/25, wander risk reassessments were initiated for Cedar Ridge residents and completed by a charge nurse. Thirteen residents were identified as being at risk.</p> <p>The RN Supervisor completed an incident report on 12/05/25, and the elopement incident was communicated verbally to oncoming staff. The incident log is reviewed during the Interdisciplinary Team (IDT) morning meeting.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?</p> <p>On 12/05/25, reeducation was conducted by the nurse supervisor on the call bell/wander guard computer alarm system and the elopement policy and procedure. The elopement policy was used to educate staff on the process to follow for a missing resident, including notification requirements and time frames. Reeducation was also provided on call bell pager and alarm response. The community utilizes pagers to alert staff of resident call bells and door alarms. Staff were instructed not to disarm the alarm without following the elopement process (outlined below). Education for WillowBrooke staff is ongoing by the DON/Designee and will be completed prior to the start of the employees' next shift. Education will also be provided to new hires by the DON/Designee.</p> <p>On 12/05/25, elopement drills and education were initiated by the charge nurse. Drills continued throughout the weekend (12/06/25 and 12/07/25). The drills involve using a stuffed bear as the "missing person." A team member calls "Code Silver" over the walkie-talkie radio three times, calling staff to a designated area. Once assembled, staff are shown a picture of the bear, and search areas are assigned both inside and outside the building. When the bear is located, it is returned to the designated area, and an "all clear" for the Silver Alert is called over the radio three times. If the resident is not located, notification is escalated up to and including law enforcement. During drills, staff received reeducation on the elopement policy, including steps to follow if a resident is missing, appropriate alarm response (including not turning off the alarm without following the elopement process), and notification requirements. Compliance with the process is monitored during each</p>	

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 3 located on the wall next to the door could be pressed to alert staff in the unit to come to the door. The rear exit door of the secure memory unit (the door that Resident #1 exited), revealed a metal door with a large clear windowpane with visibility to the outdoor area behind the facility. The wander alert keypad and a covered emergency door release button were positioned next to the rear exit door. The door had a push bar that went across the width of the door that could be pushed to open the door and had a manually lockable metal door handle which turned to open the door. Sensors for the wander alert device alarm were observed on the interior of the door. The rear exit door was 1 of 5 exits out of the secure memory care unit. All exits contained the wander alert device keypad and were locked. An attempt was made to open the rear exit door by the Surveyor by pressing the door push bar and a loud alarm was heard immediately. Staff responded to the alarm immediately and cleared the alarm by entering the alarm code in the keypad. The rear exit door that Resident #1 exited out of was the only exit point from the secure memory care unit that led directly to the outside campus and was not enclosed by a fenced-in courtyard. The other exits led to fully enclosed fenced-in courtyards with locked gates that also contained wander alert keypads.</p> <p>A review of the alarm response report dated 12/05/25 indicated Resident #1's specific wander alert device triggered the secure memory care unit rear exit door at 3:22 PM. The elopement alarm was cleared by an unknown staff at 3:24 PM (1 minute 30 seconds later). Resident #1's specific wander alert device again triggered the front door memory care unit upon return to the secure memory care unit at 3:42 PM.</p> <p>A review of the historical weather data from Weather Underground dated 12/05/25 at 3:38 PM revealed the weather in Matthews, North Carolina was foggy with a drizzle of rain. The recorded temperature was 39 degrees Fahrenheit with wind speeds of 12 miles per hour (MPH) and visibility was 1 mile.</p> <p>A review of Nurse #1's handwritten statement dated 12/05/25 revealed at 3:00 PM "Resident #1 was sitting in the dining room with Nursing Assistants and other residents".</p> <p>The investigation questionnaire completed by Nurse #1 dated 12/05/25 revealed no door alarm was heard. Nurse #1 documented no text for the wander device was received by Nurse #1 because she had transferred the pager to Nurse #2 during report. Nurse #1 indicated she did not clear the alarm. Nurse #1 observed Resident #1</p>	L0039	<p>Continued from page 3 drill.</p> <p>On 12/09/25, the Maintenance Foreman updated the preventative maintenance task to check the function and batteries of lift covers for emergency release buttons quarterly. The maintenance team receives electronic work orders for preventative maintenance tasks quarterly and as needed. Previously, batteries were checked every six months.</p> <p>How will the facility monitor its corrective actions to ensure the deficient practice will not recur?</p> <p>On 12/08/25, the DON/Designee began monitoring alarm response weekly for four weeks. This process includes reviewing the alarm response report to monitor response times (from when the alarm sounds to when it is disabled by staff) and interviewing staff to ensure the elopement policy was completed.</p> <p>On 12/05/25, the DON/Designee initiated elopement policy reviews and elopement drills weekly for four weeks. Drills will be conducted at various times on all shifts, including weekends.</p> <p>Completion of quarterly checks of screamer alarms and batteries will be monitored through the electronic maintenance system (TELS) by the Maintenance Director and Foreman beginning 12/09/25, when the quarterly checks were added to the system. The Maintenance Director and Foreman monitor open work orders daily for completion. If a work order is not completed, the Director or Foreman will follow up with their team to determine the reason.</p> <p>On 12/05/25, an ad hoc QAPI meeting was held via telephone with the Executive Director, Regional Director of Clinical Services, Nursing Home Administrator, Director of Nursing, Registered Nurse Supervisor, Care Coordinator, and Nurse Practitioner. The incident and corrective steps were reviewed. The incident was also reviewed with the Medical Director on 12/08/25 upon his return to the country.</p> <p>The results of audit findings will be reported and reviewed during the Quality Assurance Performance and Improvement (QAPI) meeting for one month by the DON/Designee.</p> <p>Completion Date:</p> <p>The completion date for the Plan of Correction is</p>	

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 4 at approximately 2:50 PM and she was calm, sitting in the dining room.</p> <p>An interview with Nurse #1 was conducted on 12/31/25 at 10:14 AM. Nurse #1 worked from 7:00 AM to 3:00 PM on 12/05/25 in the secure memory care unit. Nurse #1 reported Resident #1 was sleeping in her bed and Nurse #1 woke her up between 1:30 PM to 2:00 PM to eat lunch because she had slept through lunch. At 2:50 PM, Nurse #1 was counting the narcotics with Nurse #2 and observed Resident #1 calmly sitting in the dining room. Nurse #1 gave report to Nurse #2 and recalled she pointed out Resident #1 to Nurse #2. Nurse #1 stated that at 3:00 PM, she and Nurse #2 entered the nurse's station to complete documentation and did not observe Resident #1 further until she returned from the elopement. Nurse #1 stated that the pager was given to Nurse #2 during report and was not in her possession at the time Resident #1 eloped. Nurse #1 could not recall a specific time but sometime after 3:00 PM, the MDS Coordinator called her to report that Resident #1 had eloped and she was returned to the facility through the front entrance. Resident #1 was returned and was slightly agitated. Nurse #1 stated that Nurse #2 would complete the head-to-toe assessment as the oncoming nurse. Nurse #1 observed Resident #1 briefly and she appeared at baseline. Nurse #1 reported that Resident #1 had frequent exit seeking behaviors (i.e. walking to the door, shaking the door, and verbalizing wanting to leave) and always wore the wander alert device. Nurse #1 stated Resident #1 could be redirected at times but may become agitated when being redirected from exit seeking behaviors. Nurse #1 reported that all residents wearing wander alert devices could have their location monitored visually throughout the unit on a monitor screen in the nurse's station. If a resident with a wander alert device went near an exit door, it showed on the alarm monitor and the pager system would beep to alert staff. If an exit door was pushed or an attempt to open the door was made, it beeped very loudly and sent a text to the pager system with the location. Nurse #1 stated that she had not observed Resident #1 ever touch or attempt to open the covered emergency exit button next to the door. If Resident #1 had opened the protective plastic cover of the emergency exit button, it would have alarmed loudly and had to be reset manually. Nurse #1 stated once the exit door alarm was activated by a wander alert device, a code had to be entered into the keypad for the alarm to turn off and be reset. Nurse #1 indicated she did not hear a door alarm and did not see any staff turn off the door alarm, but when Resident #1 was brought in through the front door, the alarm was triggered by her wander alert device on 12/05/25. During Nurse #1's shift on</p>	L0039	Continued from page 4 12/10/25.	

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 5</p> <p>12/05/25, Resident #1 had no complaints of pain, and her gait was steady per baseline. Nurse #1 indicated that Resident #1 was at high risk for falls and had very poor safety awareness due to advanced dementia. Nurse #1 stated Resident #1 had a slow thought processing time; she would not be aware of hazards and was likely to put herself in a dangerous position. Nurse #1 voiced concerns for Resident #1's safety outside of the facility in relation to cars passing by, the risk of falling, attempts at crossing the road, or approaching the large pond which Nurse #1 verbalized would all attract Resident #1's attention and be a potential hazard. Nurse #1 stated that she was told Resident #1 was found walking down the road on campus but was not told specifically where she was discovered. Resident #1 returned sometime after 3:00 PM but Nurse #1 could not recall exact time specifically. Nurse #1 indicated that she did not perform any further observations of Resident #1. Nurse #1 reported that she completed documentation and when she left work between 4:30 PM and 5:00 PM, Administration was still investigating the incident.</p> <p>A review of Nurse #2's handwritten statement dated 12/05/25 revealed that at 3:15 PM Nurse #2 was obtaining shift report and counting narcotics. At 3:25 PM, staff brought Resident #1 "back from outside. When asked what she's doing outside, said "I'm just taking a walk".</p> <p>Investigation questionnaire completed by Nurse #2 dated 12/05/25 indicated no door alarms were heard and no alert on the pager system was received. Nurse #2 indicated Resident #1 was last observed by her during shift change narcotic count.</p> <p>An interview with Nurse #2 was conducted on 12/30/25 at 4:12 PM. Nurse #2 indicated that she was working from 3:00 PM to 11:00 PM on 12/05/25 and had arrived at work a little before 3:00 PM. Nurse #2 stated that she was receiving report at approximately 3:30 PM from Nurse #1 when the MDS Coordinator brought Resident #1 back to the secure memory care unit through the front door. Nurse #2 indicated that Resident #1 refused a full assessment at that time due to agitation but had no obvious injury and no complaints of pain. When Resident #1 returned to the secure memory care unit, her wander alert device was checked and was functioning properly. Nurse #2 stated she had not heard a door alarm from either the emergency exit button or the wander alert system. Nurse #2 explained once the door alarm was activated, a code had to be entered into the keypad for the alarm to turn off and be reset. If the emergency exit button was pressed, it would have to be reset</p>	L0039		

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 6 manually and would alarm loudly when the cover was lifted. Nurse #2 stated she had never observed Resident #1 attempt to open or press the emergency exit door release button. Nurse #2 indicated she did not see Resident #1 approach the rear exit door on 12/05/25. Nurse #2 verified she had received the pager from Nurse #1 during shift report but cannot recall if a pager text was received when Resident #1 eloped. Nurse #2 reported Resident #1 had an unsteady gait with poor safety awareness and was high risk for falls. Nurse #2 indicated that Resident #1 had frequent exit seeking behaviors and wore a wander alert device to prevent elopement from the secure memory care unit.</p> <p>A review of Nurse Aide (NA) #1's emailed statement sent to the Administrator, Director of Nursing of the Assisted Living facility, and the MDS Coordinator, dated 12/30/25 revealed "on December 5, 2025, as I was leaving work, I noticed Resident #1. I was able to talk with her and got her in the car safe and I brought her back to facility".</p> <p>A telephone interview was conducted on 12/30/25 at 2:43 PM with NA #1. NA #1 stated she worked from 7:00 AM to 3:00 PM on 12/05/25 in the Assisted Living Unit. NA #1 reported when she left work at around 3:15 PM, she drove the perimeter road to the exit gates and noticed Resident #1 on the gravel walking trail off the side of the road approaching the facility exit gates. NA #1 recognized Resident #1 and realized she should not be out of the facility. NA #1 indicated she pulled her car over, put on her flashers, and several other cars passed her. NA #1 could not recall the exact time she discovered Resident #1 but thought it was around 3:20 PM or 3:30 PM. NA #1 approached Resident #1 on the walking trail and reported that it took approximately 7 or 8 steps onto the walking trail from the perimeter road to reach Resident #1. NA #1 reported that Resident #1 told her she needed to get to the bank. NA #1 was able to get Resident #1 into her personal vehicle and called the facility to report Resident #1 was out on the walking trail. NA #1 reported that Resident #1 was wearing shoes, socks, pants, a long sleeve shirt, and a light pullover sweater. The weather was cold and overcast but it was not raining at the time Resident #1 was discovered. NA #1 indicated Resident #1 was not shivering, had no obvious injury, had no complaints of pain, and appeared to be at baseline. NA #1 reported her gait was her baseline gait which was slightly unsteady. NA #1 reported that she brought Resident #1 back to the main entrance of the facility and the MDS Coordinator and Administrative Assistant were in the lobby and received Resident #1 and returned her back to the memory care unit. NA #1 indicated she had no</p>	L0039		

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 7 further interaction with staff and she left the facility. NA #1 verbalized the Administrator had requested a written statement prior to 12/30/25 but she had forgotten to complete one.</p> <p>An interview was conducted with the MDS Coordinator on 12/30/25 at 4:43 PM. The MDS Coordinator indicated that she was in the facility lobby decorating on 12/05/25 when NA #1 returned Resident #1 to the facility at approximately 3:30 PM. The MDS Coordinator revealed that NA #1 had called her to tell her Resident #1 had eloped. The MDS Coordinator stated that she alerted the memory care unit staff that Resident #1 was returning and had been found by staff outside of the facility. Resident #1 was agitated when she returned and continued verbalizing a desire to go to the bank. The MDS Coordinator revealed she did not ask where NA #1 had found her and Resident #1 appeared to be at her baseline with no apparent injury. The MDS Coordinator stated that Resident #1 had an unsteady gait but ambulated independently, was high risk for falls, had poor safety awareness, and due to poor cognition and would have difficulty recognizing environmental hazards. Resident #1 had a history of exit seeking behavior but had not eloped before to her knowledge. The Administrative Assistant entered the code for the door, and the MDS Coordinator and Nurse #2 (the nurse assigned to Resident #1) assisted Resident #1 back to the secure memory care unit.</p> <p>An interview with the Administrative Assistant was conducted on 12/31/25 at 12:05 PM. The Administrative Assistant stated she worked 12/05/25 and was in the lobby with the MDS Coordinator decorating when Resident #1 returned to the facility at approximately 3:30 PM or 3:40 PM. The Administrative Assistant reported that her shift ended at 4:00 PM and it was around that time Resident #1 was returned by NA #1 via her vehicle. The Administrative Assistant indicated NA #1 stated Resident #1 was found by the crosswalks but did not specify the location. The Administrative Assistant reported Resident #1 was slightly agitated upon return and she entered the wander alert device code into the keypad and opened the secure memory care unit door for the MDS Coordinator to return Resident #1 to the secure memory care unit.</p> <p>An interview with NA #2 was conducted on 12/30/25 at 3:58 PM. NA #2 indicated that she worked from 7:00 AM to 3:00 PM on 12/05/25 and was assigned to Resident #1. NA #2 reported that she last saw Resident #1 at 3:00 PM in the dining area of the secure memory care unit. NA #2 stated she had not noted any agitation or exit seeking behavior from Resident #1 at any time that</p>	L0039		

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 8 shift. NA #2 reported Resident #1 had a wander alert device to prevent elopement because she had frequent exit seeking behavior. NA #2 stated once a resident with a wander alert device opened a door, the door alarm was activated, a code had to be entered into the keypad for the alarm to turn off and be reset. NA #2 indicated she had not observed Resident #1 ever attempt to open the covered emergency door release button. NA #2 verbalized that the pager was handed to oncoming NA but could not recall who that was during shift exchange. NA #2 stated she left at 3:10 PM when her shift ended and had not heard any door alarms during her shift.</p> <p>A review of NA #3's handwritten statement dated 12/10/25 revealed NA #3 worked from 3:00 PM to 11:00 PM on 12/05/25 and had just arrived at the secure memory care unit after she received report. NA #3 documented when she returned to the dining area, she was informed by the nurse that a resident had departed off the unit but had returned.</p> <p>Investigation questionnaire completed by NA #3 dated 12/05/25 revealed no door alarm were heard by NA #3. NA #3 indicated she was in possession of the pager, but no alert text was received on the pager. NA #3 reported that she did not clear the door alarm.</p> <p>A telephone interview with NA #3 was attempted on 12/31/25 at 12:17 PM. Unable to reach NA #3 for interview.</p> <p>A review of NA #4's handwritten statement dated 12/10/25 revealed on 12/05/25 NA #4 had just started her 3:00 PM to 11:00 PM shift on the secure memory care unit when someone came in with a resident that had left the unit. NA #4 documented she did not know how Resident #1 left the unit, and no wander alarm went off to her knowledge.</p> <p>The investigation questionnaire completed by NA #4 dated 12/05/25 revealed no door alarms were heard by NA #4 and Resident #1 had not been seen by NA #4 as she just arrived to the unit. NA #4 indicated she was in possession of the pager, but no alert text was received on the pager. NA #4 reported that she did not clear the door alarm.</p> <p>A telephone interview with NA #4 was attempted on 12/31/25 at 11:11 AM. Unable to reach NA #4 for an interview.</p> <p>The Unit Manager was not available for interview during the investigation due to medical leave.</p>	L0039		

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 9</p> <p>A review of the maintenance work history report revealed that a check of operation of the door monitors and patient wandering system (including pagers) was performed by Maintenance Director on 12/01/25. The emergency door release buttons were tested last by the Maintenance Director on 10/23/25.</p> <p>Interviews with the facility Maintenance Director were conducted on 12/30/25 at 10:41 AM and on 12/31/25 at 9:58 AM. The Maintenance Director stated he was made aware Resident #1 had exited the building through the rear exit door of the secure memory care unit on 12/05/25. He indicated he was not familiar with Resident #1. He explained that the investigation concluded that Resident #1 had opened the plastic protective cover and pushed the emergency door release button and left the secure memory care unit unsupervised. The Maintenance Supervisor verbalized he was not present at the time so was not sure if the alarm worked correctly. He indicated the emergency exit button would unlock the door but as soon as the protective cover flipped up, a loud alarm would sound. The emergency exit button function was tested quarterly by maintenance personnel. The emergency exit buttons were not connected to the pager system, so it would not have sent a message if triggered. The exit doors would not unlock unless the covered emergency door release button was pressed or the wander alert device code was entered on the keypad. He stated that even if the emergency door release button cover was lifted and the button was pressed; the wander alert device system would alarm as well when a resident was near or walked through the door. The Maintenance Director explained that the secure memory care unit had wander alert device alarms at each point of exit. These door alarms would alarm loudly and alert staff via a pager text message if a resident wearing a wander alert device was near an exit door or pressed the handle. A code must be entered on the keypad by the staff to clear the wander alert device system alarm. The wander alert door alarms are tested weekly by maintenance personnel. This included checking the door sensors, the keypad, and pagers. The Maintenance Director stated on 12/05/25 after Resident #1 eloped, he went through the secure memory care unit and tested each exit point for the proper function of the wander alert device system, the pager, and the covered emergency door release buttons. He indicated no issues were discovered with the functioning of the wander alert device system, the pagers, or the emergency door release button on the rear exit door of the secure memory care unit. The Maintenance Director verbalized that the emergency door release buttons required a 9-volt battery. The rear</p>	L0039		

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 10 exit door of the secure memory care unit batteries were functioning properly at the time of inspection after the elopement.</p> <p>An initial observation of Resident #1 in the secure memory care unit was conducted on 12/30/25 at 9:41 AM. Resident #1 was observed sitting in the dayroom watching television. She was frequently repositioning herself in the chair and placing her leg over the arm of the chair. She appeared calm and was making non-sensical comments about what she was watching and laughing.</p> <p>A second observation of Resident #1 in the secure memory care unit occurred on 12/30/25 at 11:36 AM and revealed her sitting in the dayroom. Staff approached Resident #1 and assisted her from a sitting to standing position. Resident #1 was observed to ambulate with a slow, unsteady gait which required stand-by assistance to the dining area for lunch. Resident #1 was pleasantly confused and unable to answer any questions. Resident #1 made no elopement attempts during observations.</p> <p>A continuous observation was conducted on 12/30/25 from 3:23 PM to 4:20 PM of the area immediately outside of the secure memory care unit rear exit door, and the suspected path Resident #1 traveled to where she was discovered and revealed the following:A rectangular concrete patio off the rear exit door.Directly across from the rear exit door, the patio transitioned into a sidewalk which ended in a grassy area which sloped into a large, depressed drainage grate approximately 2 feet from the edge of the sidewalk.The sidewalk to the left of the rear exit door (the suspected path Resident #1 took) led along the back of the facility, down 23 concrete steps to the loading dock/delivery area connected to the facility parking lot, and around to the main facility perimeter road.Three unlevel possible entry points to access the wooded, gravel walking trail directly from the facility parking lot.Resident #1 was discovered on an uneven, wooded, gravel walking trail at the main facility exit gates. This location measured approximately 1,087 feet from the rear exit door of the secure memory care unit.The walking trail ran parallel between the facility perimeter road and the main road. A wood and metal fence ran along the main road preventing direct access.The location where Resident #1 was discovered measured approximately 75 feet from a highly traveled 4-way intersection between a main 3-lane road with a posted speed limit of 35 miles per hour and approximately 30 feet from the facility perimeter road with a posted speed limit of 15 miles per hour. The 4-way intersection between these roads</p>	L0039		

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 11 also contained a 4-way stop light. A progress note dated 12/10/25 at 11:00 AM completed by the Nurse Practitioner (NP) revealed Resident #1 was seen by the NP at that time. The note revealed staff had requested assessment due to Resident #1's elopement. Resident #1 was documented as in no acute distress today and denied pain. Staff reported they had not noticed increased confusion. Resident #1 was seemingly at her baseline for provider examination. No overt findings on the physical examination.</p> <p>An interview with the NP was conducted on 12/31/25 at 9:38 AM. The NP indicated she was notified by phone on 12/05/25 that Resident #1 had eloped out of the secure memory unit but was not given any specific information except there was no injury. The NP revealed Resident #1 had dementia, ambulated independently, had poor safety awareness, and a history of exit-seeking behavior, and utilized a wander alert device. The NP stated that Resident #1 was at risk of falls due to her cognitive decline and poor safety awareness. Resident #1 had a steady gait on flat, even surfaces but uneven ground such as gravel would increase the risk of falls. The NP indicated Resident #1 had severe cognitive impairment, but thought Resident #1 may have enough awareness to step out of the way of a moving vehicle or navigate steps safely but was not sure. The NP reported that on 12/10/25 she assessed Resident #1 who appeared at baseline and had no injury noted and did not recall leaving. The NP verbalizes there was potential for Resident #1 to fall and be injured, become confused, become lost and not be found if she was out of the secure memory care unit unassisted.</p> <p>An interview was conducted with the Director of Nursing (DON) on 12/31/25 at 12:22 PM. The DON stated she was aware of the incident and was familiar with Resident #1. The DON indicated that she was off on 12/05/25, so the Administrator had completed the investigation. However, she was still called and notified about the elopement on 12/05/25 and attended a meeting about the incident. The DON verbalized that the investigation concluded that Resident #1 must have lifted the emergency door release button cover and pressed the emergency door release button which unlocked the door. The DON verbalized that Resident #1 had not been observed lifting the emergency door release button cover or pressing the button before, but she had pulled fire alarms before, so she felt it was possible she had. The DON stated that the emergency door release button at the rear exit door of the memory care unit did have to be manually reset which indicated to them Resident #1 had pressed it. It could not be determined if the emergency door release button alarmed correctly</p>	L0039		

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 12 because it would not send a message to the pager and the DON was not present. The wander alert device alarm did alarm correctly, but no staff recalled receiving a text on the pager, nor admitted they cleared the alarm with the code at 3:24 PM as recorded on the alarm response report. Due to being unable to determine which staff cleared the alarm, all staff had to be reeducated. The DON explained that staff present failed to follow the elopement protocol by not going outside to determine if any residents were out of the facility. The staff also failed to immediately perform a headcount on all residents to determine if there were any missing. The DON stated that Resident #1 was discovered by NA #1 on the walking trail by the facility gates, but it could not be determined which path Resident #1 took to get there. Resident #1 ambulated independently, and they estimated she was discovered approximately 6 minutes after leaving the secure memory care unit but could not explain how they reached that time frame. The DON indicated that Resident #1 would be unlikely to recognize hazards due to her cognitive decline from dementia.</p> <p>A telephone interview with the Administrator was conducted on 12/31/25 at 12:40 PM. The Administrator reported that the MDS Coordinator notified her Resident #1 had been found on the walking trail by the facility exit gates by NA #1 at approximately 3:30 PM on 12/05/25. Resident #1 had returned to the secure memory care unit with no injury. The incident was immediately investigated and the Administrator determined Resident #1 had lifted the protective cover and pressed the emergency door release button without it alarming. The wander alert device door alarm did alarm correctly when Resident #1 exited, and stated the pagers were not the issue and functioned correctly. The Administrator stated that an unknown staff disarmed the wander alert alarm and staff failed to check outside for missing residents. The Administrator stated the NP and Resident Representative were notified on 12/05/25 of Resident #1's elopement. The Administrator stated she would expect the residents in the memory care unit to remain in the unit and not exit the unit alone.</p> <p>The Administrator and DON were notified of the A-2 violation (a violation which resulted in substantial risk that death or serious physical harm would occur) on 12/31/25 at 3:38 PM.</p> <p>The facility provided the following A-2 past corrected plan:</p> <p>How will corrective action be accomplished for those residents found to have been affected by the deficient</p>	L0039		

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 13 practice?</p> <p>On 12/05/25, Resident #1 exited the Cedar Ridge neighborhood (a secure memory care unit). The resident lifted the cover over the emergency door release button (screamer alarm), but the alarm did not sound. She then pressed the door release button, which unlocked the door and allowed her to leave the secure memory care unit. The resident's wander alert device activated the wander alert system, which alarmed at 3:22 PM. The alarm was disarmed at 3:24 PM by an unidentified staff member.</p> <p>The resident was located on 12/05/25 outside the back of Willowbrooke Court near the exit gate at 3:34 PM by NA #1. NA #1 notified the Administrator via telephone and assisted the resident into her car. NA #1 then escorted the resident back to Willowbrooke Court at 3:43 PM.</p> <p>On 12/05/25, Nurse #2 evaluated Resident #1 for injury, pain, or discomfort; no adverse findings were noted.</p> <p>On 12/05/25, a headcount of Cedar Ridge residents was conducted by nursing staff, and it was verified that all residents were present in the secure memory care unit.</p> <p>On 12/05/25, Resident #1 was placed on 30-minute safety checks. These checks were currently ongoing. On 12/06/25, an additional staff member was added to the Cedar Ridge neighborhood to assist with resident oversight. The Administrator and DON directed that an additional NA be assigned to the neighborhood; this measure remained in place until 12/17/25.</p> <p>On 12/05/25, the Maintenance Director assessed the wander alert device system's alarm panels and exit doors. He verified that the alarm panels and exit doors were functioning properly. The secure memory care unit had 5 exit doors, all equipped with wander alert alarm panels. The Maintenance Director tested the system using a wander guard pendant to confirm that the alarm panel activated when the pendant crossed the threshold. He also confirmed that the door did not unlock when the pendant was near the exit door. When the emergency door release button is activated, it unlocks the door. When the wander alert device crosses the threshold, the wander alert device alarm would also sound.</p> <p>On 12/05/25, the Maintenance Director assessed the lift cover for the emergency release button on all doors in the secure memory care unit. The lift cover was a flip-style shield that covers the emergency door</p>	L0039		

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 14 release button. Once lifted, a "screamer alarm" sounds as a deterrent. Batteries for screamer alarms were replaced as needed.</p> <p>On 12/05/25, the Unit Manager notified the Nurse Practitioner and the family that Resident #1 had eloped from the facility.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>On 12/05/25, physician orders for all secure memory care unit current residents were reviewed by the Unit Manager to determine who utilized a wander alert device. Residents with wander alert devices were verified to have a current physician order in place. The Unit Manager then verified the function and placement of each wander alert device. This was verified using a handheld device called the Code Alert system, which lights up green to confirm that the pendant was active.</p> <p>On 12/06/25, elopement risk reassessments were initiated for the secure memory care unit residents and completed by a nurse. Thirteen residents were identified as being at high risk for elopement.</p> <p>Nurse #2 completed an incident report on 12/05/25, and the elopement incident was communicated verbally to oncoming staff. The incident log was reviewed during the next Interdisciplinary Team (IDT) morning meeting.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?</p> <p>On 12/05/25, reeducation was conducted by the DON on the wander alert device alarm system and the elopement policy and procedures. The elopement policy was used to educate staff in the process to follow for a missing resident, including notification requirements and time frames. Reeducation was also provided on the call bell pager and alarm response. The community utilizes pagers to alert staff of resident call bells and door alarms. Staff were instructed not to disarm the alarm without following the elopement process. Education for Willowbrooke staff is ongoing by the DON/Designee and will be completed prior to the start of the employees' next shift. Education will also be provided for new hires by the DON/Designee.</p> <p>On 12/05/25, elopement drills and education were initiated by the DON. Drills continued throughout the</p>	L0039		

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 15 weekend (12/06/25 and 12/07/25). The drills involved using a stuffed bear as the "missing person." A team member calls "Code Silver" over the walkie-talkie radio three times, calling staff to a designated area. Once assembled, staff were shown a picture of the bear, and search areas were assigned both inside and outside of the building. When the bear was located, it was returned to the designated area, and an "all clear" for the Silver Alert was called over the radio three times. If the resident was not located, notification was escalated up to and including law enforcement. During the elopement drills, staff received reeducation on the elopement policy, including steps to follow if a resident was missing, appropriate alarm response (including not turning off the alarm without following the elopement process), and notification requirements. Compliance with the process was monitored during each drill.</p> <p>On 12/09/25, the Maintenance Director updated the preventative maintenance task to check the function and batteries of lift covers for emergency release buttons quarterly. The maintenance team receives electronic work orders for preventative maintenance tasks quarterly and as needed. Previously, batteries were checked every six months.</p> <p>How will the facility monitor its corrective actions to ensure the deficient practice will not recur?</p> <p>On 12/08/25, the DON/Designee began monitoring alarm response weekly for four weeks. This process includes reviewing the alarm response reports to monitor response times (from when the alarm sounds to when it was disabled by staff).</p> <p>On 12/05/25, the DON/Designee initiated elopement policy reviews and elopement drills weekly for four weeks. Drills would be conducted at various times and occurred on all shifts, including the weekends.</p> <p>Completion of quarterly checks of the emergency door release button and batteries will be monitored through the electronic maintenance system (TELS) by the Maintenance Director beginning on 12/09/25. The Maintenance Director will monitor open work orders daily for completion. If a work order was not completed, the Maintenance Director will follow up with their team to determine the reason.</p> <p>On 12/05/25, an ad hoc Quality Assurance Performance and Improvement (QAPI) meeting was held via telephone with the Executive Director, Regional Director of Clinical Services, Nursing Home Administrator, Director</p>	L0039		

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 16 of Nursing, Registered Nurse Supervisor, Care Coordinator, and Nurse Practitioner. The incident and corrective steps were reviewed. The incident was also reviewed with the Medical Director on 12/08/25 upon his return to the country.</p> <p>The results of audit findings will be reported and reviewed during the QAPI meeting for one month by the DON/Designee.</p> <p>Completion Date:</p> <p>The completion date for the Plan of Correction was 12/10/25.</p> <p>Date of Compliance: 12/10/25</p> <p>Alleged date of the A-2 violation past correction date: 12/10/25</p> <p>An onsite validation was conducted on 12/30/25 and 12/31/25 with further information obtained offsite through 01/05/26. In-service records and interviews with staff across all departments revealed they had been educated on ensuring safety of residents that resided on the secure memory care unit and exhibited wandering or exit seeking behaviors. Staff were also educated on facility policies and procedures for resident elopement. This reeducation included notification of a supervisor or administrative staff of any changes in resident behavior, or any resident safety concerns regarding elopement. Staff were also educated about the importance of monitoring the location of their assigned residents throughout the unit during their shift. All staff voiced understanding they were to ensure the secure memory care unit exit doors were closed properly and assess the residents who utilized wander alert devices for proper functioning each shift. Staff from all shifts participated in the facility elopement drills to demonstrate practical knowledge received during their elopement training.</p> <p>Nursing staff were educated on completing accurate elopement risk assessments by reviewing previous assessments, care plans, progress notes, and completing accurate observations of residents. Nurses were also educated that changes in condition or new behaviors pertaining to wandering or exit seeking were being accurately documented and nursing supervisors were notified.</p> <p>Interviews with the maintenance department revealed they had received education on resident elopement policy and procedures, participated in the elopement</p>	L0039		

North Carolina State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Willowbrooke Court SC Ctr at Matthews Glen			STREET ADDRESS, CITY, STATE, ZIP CODE 740 Pavilion View Drive , Matthews, North Carolina, 28105	
(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
L0039	<p>Continued from page 17 drills, and had increased maintenance checks from monthly to weekly of the exit door alarms on the memory care unit. The emergency door release button batteries would now be assessed quarterly for proper function.</p> <p>The facility safety committee meeting was held on 12/05/25 to discuss the elopement incident, and to develop and implement a safety plan to ensure no further residents were at risk for elopement. Plan was reviewed with no issues.</p> <p>Interviews with the administrative staff revealed audits were performed for all residents to ensure they had accurate and updated elopement risk assessments completed. Administrative staff completed weekly audits of alarm response monitoring times. The Administrative staff were also completing the education, audits, and monitoring of staff to ensure residents' safety.</p> <p>The facility's past corrected date of 12/10/25 was validated on 12/31/25.</p>	L0039		