STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 01/25/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 1/22/19 through 1/25/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # XY8J11	E 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for	F 604		2/21/19

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

Electronically Signed — 02/18/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 01/25/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 1 restraints. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain an environment free from physical restraints for 1 of 2 (Resident # 275) residents reviewed for restraints by placing pajama bottoms to prevent rising. Findings included: Resident #275 was admitted to the facility on 3/16/18 and resided in the memory care unit. Diagnoses included: Right hip fracture and dementia without behavioral disturbance. A review of the quarterly Minimum Data Set assessment dated 7/20/18 revealed Resident #275 had severely impaired cognition and required extensive assistance with two people for transfers. Restraint was not coded on the assessment. A record review revealed no physicians order for a restraint, no assessment for a restraint and restraints were not care planned. A care plan updated 7/20/18 was reviewed for safety that revealed resident had poor safety awareness and had confusion. Interventions included gripper socks, fall mat at bedside and maintain a clear pathway. An interview on 1/24/19 at 2:40 PM with the Administrator revealed she did not recall an incident involving a resident being restrained by a nursing assistant. An interview on 1/24/19 at 3:45 PM with NA #1	F 604	1) Resident # 75 no longer resides in the facility. On 01/24/2019, NA #1 received education from the Director of Nursing on restraint use. The facility maintains a restraint free environment including during emergency situations. 2) On 01/25/2019, the Director of Nursing and or Nursing Supervisor, through personal observation of residents, ensured residents are free of restraints and the facility is maintaining a restraint free environment. 3) The Director of Clinical Services and or Nursing Supervisor educated licensed nurses and certified nursing assistants on restraint use and the facility maintaining a restraint free environment including in emergency situations by 02/20/2019. The Director of Clinical Services and or Nursing Supervisor educated Licensed nurses on reporting and documentation standards related to the use of restraints. Newly hired employees will receive restraint free education during orientation by 02/20/2019. The Executive Director, Director of Clinical Services and or Nursing Supervisor to perform Quality Improvement Monitoring by observing residents during monthly fire drills or upon activation of the fire alarm to ensure residents are placed in a safe area and are without restraints. 4) On 02/21/2019, the Executive Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 01/25/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 2 revealed she was working in the memory care unit on the night of 5/31/18 during second shift when the fire alarm went off. She stated the staff were supposed to put all of the residents in their rooms. She stated she was putting Resident #275 in her room and didn't want her to fall, so she loosely placed her pajama bottoms around her waist. She stated another staff member came in and saw the pants applied to Resident #275's waist and went to get Unit Manager #2 who came back and instructed her to clock out after she wrote a statement. She stated she was educated by Unit Manager #2 that the facility was restraint free, residents could not be restrained for any reason. An interview on 1/24/19 at 4:17 PM with the Activity Director for the memory care unit revealed she was in the facility the evening of 5/31/18 but was not working. She stated when the fire alarm went off, she went to the memory care unit to assist the staff and residents. She and other staff were putting the residents into their rooms. After the alarm stopped sounding, she observed Resident #275 sitting at one of the tables and noted a color variation to her clothing and looked further to see their was fabric tied to her. She stated she immediately went to report to Unit Manager #2 who went to the unit. The Activity Director stated NA #1 was instructed to leave and Unit Manager #2 educated the other staff about restraints. She stated she was asked to provide a written statement, which she did do. An interview on 1/25/19 at 8:31 AM with Unit Manager #2 revealed she no longer worked at the facility. She stated on the evening of 5/31/18, she was in the front of the building working on the	F 604	will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director, Director of Clinical Services and or Nursing Supervisor. Results of Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained, monthly for three months and then quarterly for 2 quarters . Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 01/25/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 3 schedule when the fire alarm went off. She stated that prior to that incident, the fire alarm had been going off frequently and the facility was having problems with it. She stated the Administrator was in the facility at the time. She stated the Activity Director came and told her that she had seen a resident restrained. Unit Manager #2 stated she immediately went to the memory care unit and removed the pants. She stated she instructed NA #1 to clock out then notified Unit Manager #3 who notified the Administrator. She stated she also provided a written statement. An interview on 1/25/18 at 10:12 AM with Unit Manager #3 revealed she also no longer worked at the facility. She stated she was working the evening of 5/31/18 when the fire went off at approximately 4:45 PM. She stated Unit Manager #2 notified her that Resident #275 had been restrained. Unit Manager #3 went to the conference room to notify the Administrator. Unit Manager #3 stated she also provided a written statement that was turned into the Administrator. A follow up interview with the Administrator on 1/25/18 at 2:47 PM revealed she could not recall the incident and was unable to locate any of the documentation about it. She stated the facility is restraint free.	F 604		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		2/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 01/25/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 4 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff	F 655	1) Resident # 73�s baseline care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 01/25/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 655 Continued From page 5

interviews, the facility failed to develop a baseline care plan that included minimum healthcare information to provide effective, person-centered care for a resident with an indwelling catheter for 1 of 2 (Resident #73) residents reviewed for catheters.

Findings included:

Resident #73 was admitted to the facility on 12/21/18 with diagnoses of acute cystitis and bladder outlet obstruction.

A review of an admission Minimum Data Set assessment dated 12/28/18 revealed Resident #73 had severely impaired cognition and had an indwelling catheter.

A review of the baseline care plan dated 12/23/18 revealed, under a problem of Altered Elimination, a goal of: will be odor free without skin breakdown. Interventions included: incontinent care as needed and monitor skin. Indwelling catheter was not included on Resident #73's baseline care plan.

An observation on 1/22/19 at 4:55 PM revealed Resident #73 in his wheelchair with a catheter tube and drainage bag under the wheelchair.

An interview on 1/24/19 at 3:30 PM with NA #2 revealed Resident #73 had an indwelling catheter.
She revealed he was admitted with it. NA #2 was responsible for catheter care.

An interview on 1/25/19 at 5:09 PM with the Director of Nursing revealed she expected indwelling catheters to be included on the

F 655

was updated on 01/25/2019 to reflect that resident was admitted with catheter on 12/21/2018. On 01/25/2019, the Director of Nursing educated Nurse # 1 on completing the base line care plan that includes the minimum healthcare information to provide effective, person-centered care for residents with an indwelling catheter.

2) The Director of Nursing and or Nursing Supervisor reviewed the last 30 days of baseline care plans for residents admitted with catheter to ensure accuracy of the baseline care by 02/15/2019.

3) The Director of Nursing and or Nursing Supervisor educated licensed nurses on developing a baseline care plan that includes minimum healthcare information including those admitted with indwelling catheters by 02/20/2019. Newly hired nurses will receive education during orientation. The Director of Nursing, Nursing Supervisor and or MDS Coordinator will perform Quality Improvement Monitoring by observation of residents admitted with an indwelling catheter 2 times a week for 4 weeks then 1 times a week for 4 weeks.

4) On 02/21/2019, the Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director or Director of Clinical Services and or Nursing Supervisor. The results of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 01/25/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 6 baseline care plan. An interview on 1/25/19 at 5:14 PM with Nurse #1 revealed the nurse was responsible for implementing the baseline care plan. She stated she was on duty when Resident #73 was admitted and she completed the baseline care plan. She revealed Resident #73 was admitted with an indwelling catheter and she overlooked putting it on the baseline care plan.	F 655	Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained, monthly for three months and then quarterly for two quarters. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.	
F 658 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 observations, record reviews, resident and staff interviews, the facility failed to follow-up on the Registered Dietician's diet change recommendation for 1 of 1 resident receiving dialysis treatment (Resident #70). Findings included: Resident #70 was originally admitted to the facility	F 658	1) Resident # 70 diet change recommendation from Registered Dietician was communicated to the physician on 01/25/2019. The physician wrote an order on 01/25/2019 for Resident # 70 to continue on a regular diet with 32 ounce per day fluid restriction. On 01/25/2019, Unit Manager # 1 was educated by the Director of Nursing on reviewing, communication with the	2/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 01/25/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 658 Continued From page 7
on 12/12/18 and re-admitted on 1/10/19 with diagnoses which included: end-stage renal disease, adult polycystic kidney disease and diverticulitis.

The Care Plan dated 12/18/18 revealed Resident #70 had the potential for imbalanced nutrition and received a therapeutic diet. Interventions included: observe and report to the Physician signs and symptoms of malnutrition; and, RD (Registered Dietician) to evaluate and make diet change recommendations whenever necessary.

The Initial Nutrition Assessment dated 12/18/18 documented Resident #70 received dialysis treatment three times each week and received a cardiac diet. The RD recommended the resident receive a change in diet to a renal diet.

There was no documentation available indicating the RD's diet change recommendation was communicated to the Physician.

Review of the significant change minimum data set dated 1/17/19 indicated Resident #70 was cognitively intact, received a therapeutic diet and received dialysis treatment.

During an interview on 1/23/19 at 4:10 p.m., Resident #70 revealed she was not on a renal diet, but did not think she should continue to receive potatoes with her meals because of her renal condition. The resident stated that when the facility served potatoes, she left them uneaten on her plate. Review of the resident's meal card indicated she received a regular diet.

The review of the Dialysis Communication Record dated 1/25/19 included the

F 658

physician and documenting on recommendations from the Registered Dietician.

2)The Director of Nursing and or Nursing Supervisor reviewed the last 30 days of diet recommendations from the Registered Dietitian to ensure the recommendation was communicated to the physician and documented in the chart by 02/15/2019.

3) The Director of Nursing and or Nursing Supervisor educated licensed nurses on diet recommendations from the Registered Dietitian to ensure recommendation is communicated to the physician and documented by 02/20/2019. Newly hired nurses will receive education during orientation. The Director of Nursing and or Nursing Supervisor will perform Quality Improvement Monitoring of 2 residents diet change recommendation from Registered Dietitian 2 times a week for 4 weeks, then 1 times a week for 4 weeks.

4) On 02/21/2019, the Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director or Director of Clinical Services/Nursing Services. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 01/25/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 8 recommendation from the dialysis center to encourage protein intake, follow renal diet, and a 32 ounce per day fluid restriction. During an interview on 1/25/19 at 2:59 p.m., Unit Manager#1 stated that the RD was to document any recommended orders on a facility Communication Form, and give the recommendation to the Unit Manager or the Director of Nursing who would then write the telephone order. Unit Manager#1 indicated she did not recall receiving any such recommendation from the RD.	F 658	Services to ensure compliance is achieved and maintained, monthly for three months and then quarterly for two quarters. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		2/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 01/25/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 690 Continued From page 9

and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews, the facility failed to obtain a physician ' s order for an indwelling catheter and failed to attempt removal of an indwelling catheter for 1 of 2 (Resident #73) residents reviewed for catheters.

Findings included:

Resident #73 was admitted to the facility on 12/21/18 with diagnoses of acute cystitis and bladder outlet obstruction.

A review of an admission Minimum Data Set assessment dated 12/28/18 revealed Resident #73 had severely impaired cognition and had an indwelling catheter.

A review of the physician ' s orders for December 2018 and January 2019 revealed no order present for indwelling catheter.

A review of a physician ' s progress note dated 12/22/18 revealed a trial of catheter

F 690

1) Resident # 73 catheter was removed by a licensed nurse on 01/28/2019. On 01/25/2019, The Director of Nursing educated Unit Manager # 1 on residents admitted to the facility with a catheter with a diagnosis for the catheter and the requirement of a physician order, if the physician determines that the catheter should be removed, prior to an attempt to remove an indwelling catheter.

2) The Director of Nursing and or Nursing Supervisor reviewed the last 30 days of resident admitted with a catheter to ensure there is a diagnosis for the catheter, the resident is assessed to attempt to remove the catheter and a physicians order was obtained by 02/15/2019.

3) The Director of Nursing and or Nursing Supervisor educated licensed nurses on ensuring there is a diagnosis for residents admitted with a catheter, the resident is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING ______ B. WING ______	C 01/25/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 10	F 690		

discontinuation would seem to be reasonable.

A review of a physician ' s progress note dated 1/16/19 again revealed a trial of catheter discontinuation would seem to be reasonable.

An observation on 1/22/19 at 4:55 PM revealed Resident #73 in wheelchair in hallway with catheter tubing and a drainage bag under his wheelchair.

An interview on 1/24/18 at 3:30 PM with NA #2 revealed Resident #73 had an indwelling catheter.

An interview on 1/25/19 at 11:16 AM with the physician revealed he meant to put Resident #73 on Flomax for couple of days than attempt catheter removal but did not. He stated a trial of removal should be attempted.

An interview on 1/25/19 at 4:30 PM with Unit Manager #1 revealed when a resident is admitted, the nursing staff makes sure there is a diagnosis for the catheter and the physician decides if it should be removed. She stated if the physician to address the catheter removal, the nurse would be responsible for reminding him.

An interview on 1/25/19 at 5:09 PM with the Director of Nursing revealed the physician progress note gets dictated and sent to the facility to Medical Records for filing. She stated orders are either called in or written by the physician and there was not a process for reviewing the progress notes. She revealed she expected residents with indwelling catheters to have physician ' s orders.

accessed for removal of the catheter and obtain an order from the physician to attempt removal of an indwelling catheter by 02/20/2019. Newly hired nurses will receive education during orientation. The Director of Nursing and or Nursing Supervisor to perform Quality Improvement Monitoring of residents admitted with a catheter 2 times per week for 4 weeks, then 1 times a week for 4 weeks.

4) On 02/21/2019, the Executive Director to present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director or Director of Clinical Services and or Nursing Supervisor. The results of the Quality Improvement Monitoring to be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained, monthly for three months and then quarterly for two quarters. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.