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 _____	01/30/2020

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 1/27/20 through 1/30/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID 9V6111.	E 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		2/27/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/22/2020

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based observations, record review and staff interviews, the facility failed to ensure a resident ' s dignity by not providing privacy during incontinent care and talking on a cellular phone while providing care for 1 of 1 resident (Resident #45) reviewed for dignity. The findings included: Resident # 45 was admitted to the facility on 11/2/19 with a diagnosis of dementia with behavioral disturbance. A review of a quarterly Minimum Data Set assessment dated 12/13/19 revealed Resident #45 had severely impaired cognition, was always incontinent of bowel and bladder and required extensive assistance of two people for her activities of daily living. On 1/28/20 at 10:28 AM, the surveyor toured the locked unit. Upon arriving to Resident #45 ' s room, the surveyor observed Resident #45 ' s room door open, the privacy curtain partly pulled closed and Resident #45 ' s legs uncovered. NA #1 was observed leaning over the resident ' s body and using a wiping motion with her hand.	F 550	1)Resident #45 was not affected related to the citation of the privacy curtain being partly pulled and NA #1 talking on her cellphone during care. On 01/28/2020, NA #1 was educated by the Director of Nursing on providing privacy during incontinent care and use of cell phone during care. On 01/28/2020 NA #2 was educated by the Director of Nursing to ensure residents dignity providing privacy during incontinent care. 2)On 01/28/2020, the Director of Nursing or Nursing Supervisor, through personal observation of residents, ensured residents are provided privacy during care and staff was not using cell phone during care. 3)The Director of Nursing and or Nursing Supervisor educated licensed nurses and certified nursing assistants on providing privacy during care including the use of cell phones while providing care and ensuring the door is properly closed and curtain is fully pulled to ensure a residents dignity and privacy by 02/25/2020. The	

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F 550	Continued From page 2 The surveyor knocked and entered the room to pull the privacy curtain to allow Resident #45 privacy and at that time observed NA #2 assisting with the care of Resident #45 and NA #1 talking on her cellular phone which was cradled between her chin and shoulder while providing incontinent care to Resident #45. NA #1 stated "I ' m sorry, my child was throwing up." On 1/28/20 at 10:30 AM, the surveyor notified the Director of Nursing who stated she would address the concern right away. On 1/29/20 at 10:11 AM NA #2 was interviewed. She stated she pulled the curtain because the door didn ' t stay closed, but the curtain got stuck and could not be closed further. She stated the staff were not allowed to have their cellular phones in use while they are providing care. On 1/30/20 at 9:08 AM, NA #1 was interviewed. She stated on 1/28/20, her and NA #2 were providing incontinent care to Resident #45 and getting her out of bed for lunch. She stated that she did close the door to Resident #45 ' s room but it did not latch so it swung open. She stated that was when NA #2 pulled the curtain and she thought it was closed. NA #1 stated she had her cellular phone in her pocket and her child ' s school called due to illness. She stated she took the call because she wanted to be available to her child and also wanted to complete Resident #45 ' s care. NA #1 stated staff were not be on their cellular phones during care. On 1/30/20 at 3:34 PM, the Director of Nursing was interviewed. She stated they did have a problem with Resident #45 ' s door not closing all the way and she had maintenance fix it that day.	F 550	Executive Director, Director of Nursing and or Nursing Supervisor will perform Quality Improvement Monitoring by observation of residents to ensure residents dignity and residents are provided privacy during care including staff are not using cell phones while caring for residents 2 times a week for 4 weeks then 1 times a week for 4 weeks. 4)On 02/27/2020, the Executive Director will present the Plan of Correction to the Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director, Director of Nursing 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 Nursing to ensure compliance is achieved and maintained, monthly for three months and then quarterly for two quarters. Quality Monitoring schedule 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 Nursing, Nursing Supervisor, Medical Director, Social Services, Activities Director, and Minimum Data Assessment Nurse and at least one direct care staff.	

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F 550	Continued From page 3 She stated the curtain was able to be pulled all the way around the beds to provide privacy. She stated she discouraged cellular phone usage and NA #1 should not have answered the call while she was providing care.	F 550		
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 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).	F 655		2/27/20

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F 655	Continued From page 4 §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 record review and staff interviews, the facility failed to develop a baseline care plan that included individualized information to provide effective, person-centered care for a resident requiring hemodialysis and an indwelling catheter and receiving insulin for 1 of 3 (Resident #71) resident with closed records. The findings included: Resident #71 was admitted to the facility on 11/1/19 with diagnoses of, in part, end stage renal disease with dependence on renal dialysis and insulin dependent diabetes mellitus. He was sent to the hospital on 11/25/19. A nursing admission assessment dated 11/1/19 indicated Resident #71 received dialysis 3 times/week and had a shunt in his right upper arm. The assessment also indicate Resident #71 was an insulin dependent diabetic and had an indwelling catheter. An Admission Minimum Data Set (MDS) assessment dated 11/7/19 revealed Resident #71	F 655	1)Resident #71 no longer resides in the facility. 2)The Director of Nursing and or Nursing Supervisor reviewed the last 30 days of baseline care plans for new admissions to ensure the baseline care plan was completed that included individualized information to provide effective, person centered care for residents requiring hemodialysis and indwelling catheter and receiving insulin by 02/12/2020. 3)The Director of Nursing and or Nursing Supervisor educated licensed nurses on developing a baseline care plan that includes at minimum, individualized information to provide effective, person centered care for residents requiring hemodialysis and an indwelling catheter and receiving insulin by 02/27/2020. Newly hired licensed nurses will receive education during orientation. The Director of Nursing, Nursing Supervisor and or MDS Coordinator will perform Quality	

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F 655	Continued From page 5 had intact cognition and required limited assistance with most of his activities of daily living. Resident #71 used an indwelling catheter, received insulin and received dialysis while a resident of the facility. A record review revealed no baseline care plan for Resident #71. A record review revealed Daily Skilled Notes indicating Resident #71 had an indwelling catheter in place and a shunt to his right upper arm. A review of the November 2019 Medication Administration Record and revealed Resident #71 received insulin. An interview was conducted on 1/29/20 at 11:15 AM with the MDS nurse revealed baseline care plans were kept on the resident ' s charts. An interview was conducted on 1/30/20 at 1:44 PM with Unit Manager #1. She revealed the baseline care plans are completed by the nurse that completes the admission. She stated sometimes the Unit Managers help with getting them completed. An interview was conducted on 1/30/20 at 3:37 PM with the Director of Nursing. She stated Resident #71 should have had a baseline care plan because there was a packet that the admitting nurse completed when a resident was admitted, and it included the baseline care plan. She did not know why it wasn ' t in the chart.	F 655	Improvement Monitoring on newly admitted residents to ensure the baseline care plan was completed that included individualized information to provide effective, person centered care for residents requiring hemodialysis and indwelling catheter and receiving insulin 2 times a week for 4 weeks then 1 times a week for 4 weeks. 4)On 02/27/2020, the Executive Director will present the Plan of Correction to the Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director, Director of Nursing 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 Nursing to ensure compliance is achieved and maintained, monthly for three months and then quarterly for two quarters. Quality Monitoring schedule 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 Nursing, Nursing Supervisor, Medical Director, Social Services, Activities Director, and Minimum Data Assessment Nurse and at least one direct care staff	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		2/27/20

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F 842	Continued From page 6	F 842		

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted

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F 842	Continued From page 7 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain an accurate medical record regarding resident medications for 1 of 5 residents reviewed for unnecessary medications (Resident #18). The findings included: Resident #18 was admitted to the facility on 2/28/17 with diagnoses of Alzheimer ' s, dementia with behavioral disturbance dysphagia, glaucoma, hypertension, hyperlipidemia and anxiety.	F 842	1)Resident #18 no longer resides at the facility. 2)The Director of Nursing and or Nursing Supervisor reviewed the last 30 days of physician progress notes and Medication Administration Records to ensure accuracy of medications by 02/20/2020. 3)On 02/14/2020, the Executive Director and Director of Nursing discussed	

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F 842	Continued From page 8 A review of the October 2019 physician orders revealed Resident #18 was receiving the following scheduled medications: Zyrtec 5 milligrams by mouth daily, Lactulose 10 grams/15 milliliters give 15 milliliters by mouth every day, Seroquel 50 milligrams by mouth twice a day and 100 milligrams at bedtime, klonopin 1 milligram by mouth three times a day, Zoloft 75 milligrams by mouth daily, latanoprost 0.005 drops 1 drop into both eyes at bedtime, timolol maleate 0.5% drops 1 drop into each eye at bedtime. A review of a physician ' s progress note dated 10/13/19 revealed Resident #18 ' s medications had been reviewed. The medications did not accurately reflect the medications Resident #18 was prescribed and were listed as follows: amlodipine 5 milligrams daily, citalopram 20 milligrams daily, klonopin 1 milligram three times a day, docusate sodium 100 milligrams daily, donepezil 10 milligrams daily, furosemide 20 milligrams, ipratropium-albuterol 0.5 milligrams-3 milligrams (2.5 milligram base) 3 milliliters nebulizer solution, latanoprost 0.005% eye drops, lisinopril 30 milligrams daily, Lumigan 0.01% eye drop one drop each eye daily, omeprazole 20 milligrams, oxycodone 5 milligrams every 6 hours as needed, quetiapine 50 milligrams three times a day and timolol 0.25% eye drops instill one drop into affected eyes twice a day. A review of the November and December 2019 physician orders revealed the scheduled medications Resident #18 was receiving were unchanged from October 2019. A review of a physician ' s progress noted dated 12/6/19 revealed Resident #18 ' s medications	F 842	accuracy of medical records with the physician. The physician reviews the Medication Administration Record for accuracy. The resident□s physician□s progress notes will be updated to reflect: Medications □ Med list reviewed from facility MAR. See chart for details by 02/27/2020. The Director of Nursing and or Nursing Supervisor will perform Quality Improvement Monitoring of 2 resident□s physician progress notes to ensure the physician progress note is updated to reflect Medications- Med list reviewed from facility MAR. See chart for details to maintain accurate medical record regarding resident medications 2 times a week for 4 weeks then 1 times a week for 4 weeks. 4)On 02/27/2020, the Executive Director will present the Plan of Correction to the Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director, Director of Nursing 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 Nursing to ensure compliance is achieved and maintained, monthly for three months and then quarterly for two quarters. Quality Monitoring schedule may be modified based on quality monitoring findings. The Quality Assurance performance Improvement Committee members consist of but not limited to the Executive	

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F 842	Continued From page 9	F 842		

had been reviewed, however did not accurately reflect the medications Resident #18 was prescribed. The medications listed were unchanged from the physician ' s progress note dated 10/13/19.

A review of the January 2020 physician orders revealed the following changes: Zyrtec 5 milligrams was discontinued, and Zoloft was increased to 100 milligrams daily.

An interview was conducted on 1/30/10 at 2:01 PM with Unit Manager #2. She stated Resident #18 ' s physician saw residents in the evening and did his progress notes on the computer and medical records put them onto the chart. She stated she did not review the progress notes. She stated she did take the charts into the interdisciplinary meetings to discuss psychotropic medications, but she did not review the progress notes.

A message was left with the physician ' s office on 1/30/20 at 1:49 PM. The physician did not return the surveyors call; therefore, an interview could not be conducted.

An interview was conducted on 1/30/20 at 2:01 PM with the Medical Records Director. She stated the physician saw residents in the evening, completes the progress notes in this office then calls here and she prints them and files them into the resident ' s charts.

An interview was conducted on 1/30/20 at 3:37 with the Director of Nursing. She stated the physician had a private practice as well and several residents in the facility to see. She stated once the progress noted were placed on the

Director, Director of Nursing, Nursing Supervisor, Medical Director, Social Services, Activities Director, and Minimum Data Assessment Nurse and at least one direct care staff.

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F 842	Continued From page 10 charts, sometimes they reviewed the progress notes in the interdisciplinary team meetings, but there was no process to audit the chart to ensure the medications listed in the progress notes were accurate.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facilities Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor their interventions that the committee put into place following the recertification and complaint survey conducted on 1/25/2019. This was for one deficiency that was originally cited in the area of Baseline Care Plan (F655) and was recited on the current recertification survey of 1/30/2020. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. Findings included: This tag is cross referenced to: 1. F655- Baseline Care Planning-Based on observations, record review and staff interviews, the facility failed to develop a baseline care plan	F 867	1)On 02/12/2020, the center reviewed the process for base line care plans with regard to the repeat citation. The Quality Assurance Performance Improvement committee reviewed the current process for completion of baseline care plans along with a root cause analysis of the current process to determine areas of opportunity and implementation of appropriate corrective actions utilizing a Performance Improvement Plans (PIP). 2)On 02/27/2020, Facility Quality Assurance Performance Improvement (QAPI) committee will review the findings identified during annual survey 01/27/2020 □ 01/30/2020. The Executive Director will conduct the meeting that includes participation of the interdisciplinary team members as well as the Medical Director. Meeting agenda will consists the areas of concern identified	2/27/20

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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 867	Continued From page 11 that included minimum healthcare information to provide effective, person-centered care for a resident with an indwelling catheter for 1 of 2 residents (Resident #73) reviewed for catheters. During the facility's recertification survey on 1/25/19, 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 residents (Resident #73) reviewed for catheters. An interview was conducted with the Director of Nursing on 1/30/2020 at 10:32 AM who stated she was unaware of the missed baseline care plan. She futher revealed that there would be an increased attention to that in the future. An interview conducted with the Administrator on 1/30/2020 at 3:08 PM revealed the facility did have an active Quality Assessment and Assurance Committee and they met quarterly. The administrator further stated that the committee most likely would be meeting monthly to address this and other potential issues.	F 867	during the annual survey to include Residents Rights (F550), Baseline Care Plan (F655), and Resident Records (F842). Findings identified will have a plan of correction in place to include immediate correction, quality review, education and ongoing quality improvement monitoring in place to be reviewed by QAPI committee. 3)On 01/30/2020, the Executive Director and Director of Nursing was educated regarding conducting an effective QAPI committee that identifies areas of concern, using Root Cause Analysis, develop a Performance Improvement Plan (PIP) that includes goals, actions taken, person responsible, completion date, and results. By 02/27/2020, the Executive Director/ Director of Nursing/ IDT to be educated by the Vice President of Operations on conducting an effective QAPI committee that identifies areas of concern, using Root Cause Analysis, develop a Performance Improvement Plan (PIP) that includes goals, actions taken, person responsible, completion date, and results. 4)On 02/27/2020, the Executive Director will present the Plan of Correction to the Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director, Director of Nursing and or Nursing Supervisor. QAPI committee to meet weekly for four weeks, then as indicated	

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 _____	01/30/2020

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F 867	Continued From page 12	F 867	based on the QAPI findings, but at a minimum monthly thereafter to review performance improvement related to areas identified during the annual survey 01/27/2020 □ 01/30/2020. The Vice President of Operations and or Regional Director of Clinical Services will monitor and review the findings monthly for four months and randomly thereafter. Quality Monitoring schedule may be modified based on quality monitoring findings	