STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345459	A. BUILDING _____ B. WING _____	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATES	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	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 04/05/22 through 04/07/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# NOLL11.	E 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove an expired medication	F 761	Preparation and/or execution of this plan of correction does not constitute	5/5/22

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

Electronically Signed | 04/26/2022

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
	345459	A. BUILDING _____ B. WING _____	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATES	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 1	F 761		

prior to being prepared for resident administration on 1 of 2 medication carts reviewed for medication storage (Willowbrooke Medication Cart).

Findings included:

During an observation on 04/07/22 at 9:22 AM Nurse #1 removed a package of carvedilol (medication used to lower blood pressure) from the medication cart and compared the label to the Medication Administration Record then removed one tablet from the package into a small cup being used to prepare medications for administration.

During an interview on 04/07/22 at 9:22 AM Nurse #1 was asked to review the expiration date on the package of carvedilol and revealed the medication had expired on 03/31/22. Nurse #1 removed the medication from the cup she was preparing and appropriately discarded it. Nurse #1 stated she should have reviewed the expiration date before preparing to administer the carvedilol.

An interview was conducted with Director of Nursing (DON) on 04/07/22 at 11:06 AM. The DON revealed third shift checked the medication carts for expired medicine three times a week, but she didn't know the exact date when the Willowbrooke Cart was last checked. The DON stated reviewing expiration dates was part of the check before administering medications to residents and would expect Nurse #1 to check the expiration date on the label prior to removing it from the package.

An interview was conducted on 04/07/22 at 11:07

admission or agreement by the providers of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared solely as a matter of compliance with state law.

-- One resident identified as potentially affected by the alleged deficient practice. One card of expired medication, carvedilol, which was ordered for that resident, observed on the cart. Nurse #1 immediately discarded the expired medication when she reviewed the date on the package, and no expired medication was administered to the resident.

-- Medication cart reviews were conducted on 4/7/2022 after finding the single expired medication, and no other expired medications identified. Based on the medication cart review findings, no other residents had the potential to be affected by the alleged deficient practice.

-- Re-education provided to the nurses on the processes to monitor for expired medications. This education started on 4/7/2022 by the director of nursing (DON) and includes the process of third shift checking the medication cart three nights per week, as well as nurses checking the expiration dates prior to medication administration. This education will be provided by the DON/designee with a completion date of 5/2/2022. The "medication storage/disposal audit tool" was implemented on 4/25/2022 as part of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345459	A. BUILDING _____ B. WING _____	04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATES	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 2 AM with the Administrator. The Administrator stated he would expect Nurse #1 to review the medication label for the expiration date and not remove the medicine as if ready to administer when the medication had expired.	F 761	the plan of correction. This audit monitors compliance with the third shift cart checks, as well as cart checks to identify expired medications. The DON/designee will audit weekly for two months, every other week for two months, and once a month for two months. -- The completed audits will be submitted to the Quality Assurance and Performance Improvement (QAPI) Committee for six months by the DON/designee. The QAPI committee will review the results to ensure processes are effective. Overall completion date of 5/5/2022.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345459	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/7/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON EST.	**619 LAUREL LAKE DRIVE COLUMBUS, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 584	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain sheetrock and laminate flooring in resident rooms in good repair for 2 of 21 residents reviewed for environment (Residents #7 and #17). The findings included: 1. An observation on 04/05/22 at 2:37 PM revealed the wall behind Resident #7's reclining chair had multiple areas of damaged sheetrock. The sheetrock behind the chair was scraped and peeling with multiple dark scuffmarks on the wall. A follow-up observation made on 04/06/22 at 4:59 PM revealed the wall in Resident #7's room remained unchanged and in disrepair. Also noted were two areas of missing and peeling laminate flooring located in front of the reclining chair. An interview and observation were conducted on 04/07/22 at 4:13 PM with the Director of Physical Plant

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345459	A. BUILDING: _____ B. WING _____	4/7/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON EST.	**619 LAUREL LAKE DRIVE COLUMBUS, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 584	Continued From Page 1

Services (DPPS) and the Administrator. The DPPS revealed anyone who noted a repair was needed could request a work order. After observing the damaged laminate flooring and sheetrock in Resident #7's room, the DPPS stated damage to the laminate floors and sheetrock were ongoing problems. The DPPS stated he was not aware of the repairs needed in Resident #7's room and would generate a work order to repair the wall and flooring. The Administrator revealed a team was assigned to check resident rooms regularly but with the coronavirus that had stopped and he was not aware of the damaged to the wall.

2. An observation on 04/05/22 at 3:09 PM revealed the wall behind Resident #17's nightstand was noted to have several areas of scraped and peeling sheetrock with multiple dark scuffmarks on the wall.

A follow-up observation on 04/06/22 at 4:55 PM revealed the sheetrock in Resident #17's room remained damaged and in disrepair.

An interview and observation were conducted on 04/07/22 at 4:21 PM with the Director of Physical Plant Services (DPPS) and the Administrator. The DPPS revealed anyone who noted a repair was needed could request a work order. After observing the damaged sheetrock in Resident #17's room, the DPPS and Administrator stated they were not aware of the repairs needed in Resident #17's room and would generate a work order to repair the damage area on the wall.