STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	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) COMPLETE DATE
L 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 4/29/25. Additional interviews were conducted 04/30/25, therefore the exit date changed to 04/30/25. Event ID# NP3Z11. Intake NC00229659 was investigated: 1 of the 1 complaint allegations resulted in deficiency.	L 000		
L 039	.2208(E) SAFETY 10A-13D.2208 (e) The facility shall ensure that: (1) the patients' environment remains as free of accident hazards as possible; and (2) each patient receives adequate supervision and assistance to prevent accidents. This Rule is not met as evidenced by: Based on observations, record review, staff, and physician interviews, the facility failed to prevent a moderately cognitively impaired resident who resided on the locked memory care unit from being left unattended at an empty independent living apartment (Resident #2). This was for 1 of 2 residents reviewed for provision of supervision to residents. Findings included: Resident #2 was admitted to the facility on 11/09/23 with diagnoses which included	L 039	--Team members were notified by security that resident was dropped off at spouses apartment at 5:52pm. Team members immediately responded and secured resident at 5:59pm. --Any resident requiring transport from hospital to memory care potentially affected. No additional residents were affected. --A new process implemented for requests for transport provided by campus security.	5/11/25

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

Electronically Signed | 05/14/25

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L 039	Continued From page 1 non-traumatic brain dysfunction and anxiety disorder. Resident #2's quarterly Minimum Data Set dated 2/07/25 revealed he had moderate cognitive impairment and was set up help with most activities of daily living. He was also coded to walk 150 feet independently. Review of Resident #2's missing resident elopement drill dated 4/09/25 revealed the time the drill started was 5:52 PM and ended at 5:59 PM. The summary of the drill read in part that the resident went to the Emergency Room and upon return security took the resident to the spouse's independent living apartment. The wife was not at home. A neighbor called that a resident was lost in the hallway and all available staff responded to search for resident. Resident #2 was found in B Building 2nd floor hallway near the spouse's apartment. No injuries or distress noted. Staff assisted the resident back to the locked memory care unit. An interview on 4/29/25 at 12:52 PM with Security Guard #1 revealed he had been asked on 4/08/25 to transport Resident #2 from the hospital to the facility. He stated he did not know what time, but he had picked the resident up from the hospital, and on return to the facility campus had stopped by the guard house to ask where to drop the resident off. He stated that Security Guard #2 asked him to take the resident to an apartment in the B Building. Security Guard #1 stated he took the resident to the apartment, used his master key to unlock the door and let the resident inside. He stated he did not observe anyone in the apartment. Security Guard #1 stated shortly after that he received a radio call from Security Guard #2 informing him that Resident #2 was supposed	L 039	Nurses and security guards educated on the new process to request transport from hospital to skilled unit. The process included nurses completing a form with necessary information, and providing the form to security team member prior to transport, to ensure correct location of return. Education conducted by Director of Nursing and security supervisor and completed on 5/11/2025. Team members will not be allowed to work after this date until the training is completed. New hires will receive this education during their orientation period. --Audits conducted weekly for four weeks, every other week for four weeks, monthly for eight weeks, and then randomly. The audit will be completed by the director of nursing or assistant director of nursing. Results of the audits will be reviewed in the June 2025 safety meeting and July 2025 and October 2025 quality assurance meetings. --Completion date 5/11/2025.	

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L 039	Continued From page 2	L 039		

to have been dropped off at the medical unit instead of the apartment. He stated he went back to the apartment and the resident was not there. He then returned to his rounds and had no further information.

An interview on 4/29/25 at 2:57 PM with Nurse #1 revealed she had been the nurse on duty when Resident #2 was dropped off at his wife's apartment instead of the locked memory care unit. She stated that Resident #2's wife was waiting for him to return from the hospital in the memory care unit, so she had contacted Security Guard #2 and inquired about the resident. When she was informed that he had been dropped off at the B Building apartment, the DON and another staff member went to get him and he was transported to the memory care unit. She stated he was assessed and had no injuries. Nurse #1 stated she thought the resident had been dropped off at the apartment around 3:00 PM or 4:00 PM and had been located in the hallway around 5:00 PM.

An interview on 4/29/25 at 4:26 PM with the Physician revealed he was notified of Resident #2 being dropped off unattended at his wife's apartment in B Building without supervision. He stated the resident was often in his room on the memory care unit alone and he did not feel it was unsafe if the resident was unsupervised for a short period of time.

An interview on 4/29/25 at 5:55 PM with Security Guard #2 revealed he had received a phone call from an unknown staff member in the medical unit requesting someone go to the hospital to pick up Resident #2. He stated there was no call log system at the guard house and he did not know what time he had received the call. He stated he

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L 039	Continued From page 3 was not told where to take the resident when they returned to the facility. He asked Security Guard #1 to go to the hospital to get the resident. When Security Guard #1 returned to the facility with Resident #2, Security Guard #2 looked up the resident in the resident directory. He stated the resident was listed as residing in an apartment in B Building, so that was where he told Security Guard #1 to take him. About 10-15 minutes later, he received a call from an unknown staff member in the medical unit looking for Resident #2. He informed her the resident had been taken to his apartment in B Building. She told him the resident was supposed to be dropped off at the locked memory care unit at the medical unit. Security Guard #2 then radioed Security Guard #1 to tell him of the mistake. He did not know if Security Guard #1 had gone back to the apartment or not and had no further information. An interview on 4/30/25 at 11:47 AM with the Director of Nursing (DON) revealed she had called the Security office and talked to Security Guard #2 on 4/08/25. She stated she requested Resident #2 be picked up from the hospital and be dropped off at the medical unit where the locked memory care unit was located. She also stated as soon as they realized the resident had been dropped off at the B Building apartment, staff had gone to find the resident. He had been located in the hall by the apartment and safely transported to the locked memory care unit. The DON stated she had been able to determine that the resident had returned to the facility campus at 5:12 PM by reviewing the security camera.	L 039		