STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345326	A. Building B. Wing	07/08/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews with the resident, staff and Medical Doctor (MD), the facility failed to ensure treatment for a non-pressure related area of skin impairment was completed daily per the standing order for 1 of 1 sampled resident (Resident #5) reviewed for skin conditions. The findings included: Resident #5 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side and Parkinsonism (brain condition that cause slowed movements, stiffness and tremors). The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had intact cognition. He had impairment on one side of the upper and lower extremities, no skin issues and had a pressure-reducing device for the bed. Resident #5 required partial/moderate assistance with standing and bed/chair transfers and supervision or touching assistance with toilet transfers. A review of Resident #5's care plan dated 06/02/25 revealed Resident #5 had potential/actual impairment to skin integrity related to fragile skin. Interventions included to use caution when transferring or moving Resident #5 to prevent striking his arms, legs and hands against any sharp or hard surface. A staff progress note written by Nurse #1 dated 07/01/25 at 9:47 PM revealed Resident #5's family member stated that while assisting Resident #5 to the toilet, he accidentally sustained an abrasion to the right shin (front of the leg below the knee). Nurse #1 assessed Resident #5's shin and noted the area was bleeding from a small skin tear. Nurse #1 noted the area was cleaned with normal saline (sterile solution of salt and water) and dressed with a triple antibiotic ointment and gauze bandage. Review of the facility's Standing Orders for Treatment revealed in part, staff may use the following standing orders for the onset of specified symptoms or condition and the nurse will document the assessment of the symptoms and effectiveness of the measures instituted. The standing orders for treatment of skin tears noted: cleanse with normal saline and 4 x 4 gauze, pat dry with 4 x 4 gauze, approximate with thin adhesive bandages (if applicable) and cover with an adhesive border island dressing (specify size). Apply sterile gauze or self-adherent wrap that secures dressing (as needed). Change daily until healed. May use a triple antibiotic ointment, observe for redness and drainage. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's Treatment Administration Record (TAR) for the period 07/01/25 through 07/08/25 revealed no treatment order for daily dressing changes to Resident #5's right shin. During an observation and interview on 07/07/25 at 11:14 AM, Resident #5 was sitting in his wheelchair in his room watching TV. On the upper right shin was a 4 x 4 bordered gauze bandage with Nurse #2's name and the date of 07/05/25 written in red ink. Resident #5 stated he was not sure exactly how the injury happened but it wasn't painful and staff had been very good to provide treatment and change the bandage. During an observation on 07/08/25 at 9:57 AM, Resident #5 was in his room sleeping soundly while seated in his wheelchair. On the upper right shin was a 4 x 4 bordered gauze bandage with Nurse #2's name and the date of 07/05/25 written in red ink. During interviews on 07/08/25 at 9:13 AM and 10:10 AM, Nurse #3 revealed she had noticed the bandage on Resident #5's shin but when she reviewed his TAR, there were no orders for treatment. She confirmed the bandage on Resident #5's shin was dated 07/05/25. Nurse #3 explained that when initiating standing orders, the nurse was supposed to enter the treatment orders on the resident's TAR to be completed daily until healed and the orders were usually entered to be completed on the evening shift (3:00 PM to 11:00 PM). During a phone interview on 07/08/25 at 10:48 AM, Nurse #1 revealed on 07/01/25 she was informed by the Nurse Aide that Resident #5's family member had reported the wheelchair had scraped Resident #5's shin when the family member had assisted Resident #5 to the bathroom. Nurse #1 stated upon assessment, the area had some bleeding but was not an open wound so she initiated the standing orders for skin tears. Nurse #1 stated once the standing orders where initiated, the nurse was responsible for entering the order on the resident's TAR so that treatments would be completed daily until the area was healed. Nurse #1 stated she thought she had entered the treatment order on Resident #5's TAR and it was an oversight. An unsuccessful telephone attempt was made for an interview with Nurse #2 on 07/08/25 at 10:43 AM. During an interview on 07/08/25 at 11:38 AM with the Director of Nursing present, the Registered Nurse (RN) Supervisor explained once standing orders were initiated for Resident #5, the nurse should have entered the treatment orders on the TAR so that nurses would know to check/change the dressing daily until healed. During an interview on 07/08/25 at 2:07 PM, the Administrator stated she would expect for nurses to follow the standing orders for treatment and enter the orders on the resident's TAR when initiated so that nurses could document that the treatment was being done. During a phone interview on 07/08/25 at 3:54 PM, the Medical Doctor (MD) stated he was not sure of the facility's protocol but would have expected for staff to follow the standing order.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to ensure daily nurse staffing sheets accurately reflected the nursing staff who worked for 32 of 72 days reviewed (01/01/25, 01/02/25, 01/03/25, 01/04/25, 01/05/25, 01/07/25, 01/08/25, 01/10/25, 01/12/25, 01/18/25, 01/21/25, 01/26/25, 02/07/25, 02/09/25, 02/15/25, 02/20/25, 02/21/25, 02/24/25, 02/25/25, 02/27/25, 02/28/25, 03/01/25, 03/03/25, 03/05/25, 03/06/25, 03/07/25, 03/09/25, 03/14/25, 03/15/25, 03/21/25, 03/24/25, and 03/29/25). Findings included: Review of the facility's daily nurse staffing sheet revealed spaces to indicate the name of the unit, resident census each shift, and the number of staff and hours worked for Registered Nurse (RN), Licensed Practical Nurse (LPN) and Certified Nursing Assistant (CNA) for each 8-hour shift: day shift (7:00 AM to 3:00 PM), evening shift (3:00 PM to 11:00 PM) and night shift (11:00 PM to 7:00 AM). The facility's 24-hour day started on the night shift. a. The nursing staff time clock report revealed a LPN clocked in at 3:22 PM on 12/31/25 and clocked out on 8:03 AM on 01/01/25. The daily nurse staffing sheets dated 01/01/25 and 01/02/25 revealed there was no LPN on the night shifts. b. The nursing staff time clock report revealed a LPN clocked in at 3:05 PM on 01/02/25 and clocked out on 8:04 AM on 01/03/25. The daily nurse staffing sheets dated 01/02/25 and 01/03/25 revealed there was no LPN on the night shifts. c. The nursing staff time clock report revealed a LPN clocked in at 3:00 PM on 01/03/25 and clocked out at 7:35 AM on 01/04/25. The daily nurse staffing sheets dated 01/03/25 and 01/04/25 revealed there was no LPN on the night shifts. d. The nursing staff time clock reports revealed one RN clocked in at 3:15 PM on 01/04/25 and clocked out at 12:01 AM on 01/05/25 and one RN clocked in at 3:54 PM on 01/04/25 and clocked out at 7:44 AM on 01/05/25. The daily nurse staffing sheet dated 01/04/25 revealed there was only one RN on the evening shift. e. The nursing staff time clock reports revealed one LPN clocked in at 2:06 PM on 01/07/25 and clocked out at 8:06 AM on 01/08/25. The daily nursing staffing sheets dated 01/07/25 and 01/08/25 revealed there was no LPN on the night shifts. f. The nursing staff time clock reports revealed one CNA clocked in at 2:53 PM and clocked out at 11:15 PM on 01/10/25 and one CNA clocked in at 2:53 PM on 01/10/25 and clocked out at 7:37 AM on 01/11/25. The daily nursing staffing sheet dated 01/10/25 revealed there was only one CNA on the evening shift. g. The nursing staff time clock reports revealed one RN clocked in at 6:40 AM and clocked out at 11:45 PM on 01/12/25 and one RN clocked in at 7:06 PM on 01/12/25 and clocked out at 7:26 AM on 01/13/25. The daily nursing staffing sheet for 01/12/25 revealed there was only one RN on the evening shift. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	h. The nursing staff time clock reports revealed on 01/18/25 one CNA clocked in at 7:31 AM and clocked out at 3:13 PM and one CNA clocked in at 7:11 AM and clocked out at 1:12 PM. The daily nursing staffing sheet for 01/18/25 revealed there was only one CNA on the day shift. i. The nursing staff time clock reports revealed one RN clocked in at 2:40 PM on 01/18/25 and clocked out at 12:21 AM on 01/19/25 and one RN clocked in at 2:52 PM on 01/18/25 and clocked out at 8:46 AM on 01/19/25. The daily nursing staffing sheet for 01/18/25 revealed there was only one RN on the evening shift. j. The nursing staff time clock reports revealed one RN clocked in at 8:33 AM and clocked out at 11:44 PM on 01/21/25 and one RN clocked in at 2:57 PM on 01/21/25 and clocked out at 7:29 AM on 01/22/25. The daily nursing staffing sheet for 01/21/25 revealed there was only one RN on the evening shift. k. The nursing staff time clock reports revealed one CNA clocked in at 6:53 AM and clocked out at 11:03 PM on 01/26/25 and one CNA clocked in at 2:54 PM on 01/26/25 and clocked out at 7:27 AM on 01/27/25. The daily nursing staffing sheet for 01/26/25 revealed there was only one CNA on the evening shift. l. The nursing staff time clock report revealed on 02/07/25 a LPN clocked in at 7:09 AM and clocked out at 3:23 PM. The daily nursing staffing sheet for 02/07/25 revealed there was one RN and no LPN on the day shift. m. The nursing staff time clock reports revealed one CNA clocked in at 6:52 AM and clocked out at 3:25 PM on 02/09/25 and one CNA clocked in at 2:56 PM on 02/09/25 and clocked out at 7:22 AM on 02/10/25. The daily nursing staffing sheet for 02/09/25 revealed there were 1.5 CNAs on the day shift and 1.5 CNAs on the evening shift. n. The nursing staff time clock reports revealed one RN clocked in at 3:01 PM and clocked out at 11:01 PM on 02/15/25 and one RN clocked in at 3:07 PM on 02/15/25 and clocked out at 7:45 AM on 02/16/25. The daily nursing staffing sheet for 02/15/25 revealed there was only on RN on the evening shift. o. The nursing staff time clock reports revealed on 02/20/25 one CNA clocked in at 7:30 AM and clocked out at 3:10 PM and one CNA clocked in at 7:03 AM and clocked out at 3:03 PM. The daily nursing staffing sheet for 02/20/25 revealed there were 1.5 CNAs on the day shift. p. The nursing staff time clock reports revealed one CNA clocked in at 3:16 PM and clocked out at 11:35 PM on 02/21/25 and one CNA clocked in at 2:56 PM on 02/21/25 and clocked out at 7:06 AM on 02/22/25. The daily nursing staffing sheet for 02/21/25 revealed there was only one CNA on the evening shift. q. The nursing staff time clock reports revealed one CNA clocked in at 2:51 PM and clocked out at 11:50 PM on 02/24/25 and one CNA clocked in at 2:55 PM on 02/24/25 and clocked out at 7:10 AM on 02/25/25. The daily nursing staffing sheet for 02/24/25 revealed there was only one CNA on the evening shift. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	r. The nursing staff time clock reports revealed on 02/25/25 one CNA clocked in at 7:24 AM and clocked out at 3:08 PM and one CNA clocked in at 6:47 AM and clocked out at 3:12 PM. The daily nursing staffing sheet for 02/25/25 revealed there was only one CNA on the day shift. s. The nursing staff time clock reports revealed on 02/27/25 one RN clocked in at 7:00 AM and clocked out at 11:31 PM and one RN clocked in at 2:54 PM and clocked out at 11:38 PM. The daily nursing staffing sheet for 02/27/25 revealed there was only one RN on the evening shift. t. The nursing staff time clock reports revealed one CNA clocked in at 6:55 AM and clocked out at 3:21 PM on 02/28/25, one CNA clocked in at 7:16 AM and clocked out at 3:30 PM on 02/28/25, one CNA clocked in at 3:56 PM and clocked out at 8:09 PM on 02/28/25, and one CNA clocked in at 2:56 PM on 02/28/25 and clocked out at 7:22 AM on 03/01/25. The daily nursing staffing sheet for 02/28/25 revealed there were 1.5 CNAs on the day shift and 1.5 CNAs on the evening shift. u. The nursing staff time clock reports revealed on 03/01/25 one CNA clocked in at 7:07 AM and clocked out at 3:24 PM, one CNA clocked in at 7:20 AM and clocked out at 3:18 PM, and one CNA clocked in at 7:00 AM and clocked out at 8:08 PM. The nursing staff time clock reports also revealed one RN clocked in at 3:08 PM on 03/01/25 and clocked out at 12:01 AM on 03/02/25 and one RN clocked in at 3:00 PM on 03/01/25 and clocked out at 7:30 AM on 03/02/25. The daily nursing staffing sheet for 03/01/25 revealed there were only 1. 5 CNAs on the day shift and one RN on the evening shift. v. The nursing staff time clock reports revealed on 03/03/25 one CNA clocked in at 6:53 AM and clocked out at 3:11 PM and one CNA clocked in at 7:25 AM and clocked out at 3:11 PM. The daily nursing staffing sheet for 03/03/25 revealed there were only 1.5 CNAs on the day shift. w. The nursing staff time clock reports revealed on 03/05/25 one CNA clocked in at 6:53 AM and clocked out at 8:00 PM and one CNA clocked in at 7:00 AM and clocked out at 3:15 PM. The daily nursing staffing sheet for 03/05/25 revealed there were only 1.5 CNAs on the day shift. x. The nursing staff time clock reports revealed one CNA clocked in at 3:33 PM and clocked out at 11:40 PM on 03/06/25, one CNA clocked in at 4:17 PM and clocked out at 11:02 PM on 03/06/25, and one CNA clocked in at 3:02 PM on 03/06/25 and clocked out at 7:01 AM on 03/07/25. The daily nursing staffing sheet for 03/06/25 there was only one CNA on the evening shift. y. The nursing staff time clock reports revealed one CNA clocked in at 3:17 PM and clocked out at 11:38 PM on 03/07/25 and one CNA clocked in at 2:56 PM on 03/07/25 and clocked out at 7:10 AM on 03/08/25. The daily nursing staffing sheet for 03/07/25 revealed there was only one CNA on the evening shift. z. The nursing staff time clock reports revealed one CNA clocked in at 6:52 AM and clocked out at 10:28 PM on 03/09/25 and one CNA clocked in at 2:56 PM on 03/09/25 and clocked out at 7:15 AM on 03/10/25. The daily staffing sheet for 03/09/25 revealed there was only one CNA on the evening shift. aa. The nursing staff time clock reports revealed one LPN clocked in at 3:14 PM on 03/14/25 and clocked out at 7:58 AM on 03/15/25 and one RN clocked in at 10:51 PM on 03/14/25 and clocked out at 7:21 AM on 03/15/25. The daily nursing staffing sheets for 03/14/25 and 03/15/25 revealed there was only one RN and no LPN on the night shifts. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	bb. The nursing staff time clock reports revealed one CNA clocked in at 3:08 PM and clocked out at 11:13 PM on 03/21/25 and one CNA clocked in at 2:55 PM on 03/21/25 and clocked out at 7:13 AM on 03/22/25. The daily nursing staffing sheet for 03/21/25 revealed there was only one CNA on the evening shift. cc. The nursing staff time clock reports revealed one CNA clocked in at 2:58 PM and clocked out at 11:13 PM on 03/24/25 and one CNA clocked in at 2:54 PM on 03/24/25 and clocked out at 7:13 AM on 03/25/25. The daily nursing staffing sheet for 03/24/25 revealed there was only one CNA on the evening shift. dd. The nursing staff time clock reports revealed one CNA clocked in at 2:57 PM and clocked out at 11:10 PM on 03/29/25 and one CNA clocked in at 3:02 PM on 03/29/25 and clocked out at 7:11 AM on 03/30/25. The daily nursing staffing sheet for 03/29/25 revealed there was only one CNA on the evening shift. During an interview on 07/08/25 at 2:49 PM, the Health Services Coordinator revealed the daily nursing staffing sheets were filled out and posted by the evening shift nurse. The Health Services Coordinator explained around the first part of the year (2025) the former receptionist was updating the daily nursing staffing sheets as needed but currently she (Health Services Coordinator) was the person responsible for updating the nurse staffing sheets when they were collected daily. During an interview on 07/08/25 at 3:32 PM, the Administrator revealed the Administrative Assistant who works along side the Health Services Coordinator will be the person responsible for updating the daily nursing staffing sheets but she was currently learning the process. The Administrator stated the daily nursing staffing sheets should be updated as needed to reflect the actual nursing staff that worked each shift.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to discard expired food and milk available for use in 1 of 2 walk-in refrigerators (produce refrigerator) in the main kitchen and 1 of 2 nourishment refrigerators. This practice had the potential to affect the food served to residents. The findings included: 1. During the initial tour of the main kitchen on 7/7/25 from 10:20 AM to 10:45 AM with the Lead Chef, an observation of the walk-in produce refrigerator revealed a box of red and green bell peppers. There were four red bell peppers and three green bell peppers inside the box. Three of the four red bell peppers were covered with gray and white fuzz. There was no date on the box. The Lead Chef went through the box and discarded three of the red bell peppers that had fuzz. An interview with the Lead Chef on 7/7/25 at 10:45 AM revealed the shelf life of the bell peppers varied and depended on when they received it from their supplier. He stated that he couldn't say for sure how long they lasted because he wasn't the one who received the bell peppers, but they must have been in the produce refrigerator for at least a week. The Lead Chef stated that he saw one red bell pepper that had fuzz this morning, and he had to cut around the bell pepper to serve for the breakfast meal. He said he didn't see the other red bell peppers with fuzz, but they should have been discarded. An interview with the Dietary Manager on 7/8/25 at 1:18 PM revealed the bell peppers should have been inspected for fuzz whenever they received them from the suppliers, and daily by the chef before starting service. An interview with the Administrator on 7/8/25 at 4:15 PM revealed she was not sure how the expired bell peppers were left in the produce refrigerator, but that she would have expected them to be discarded. 2. An observation of one of the nourishment refrigerators with the Lead Chef on 7/7/25 at 11:15 AM revealed a gallon of regular milk with a best if used by date of 7/3/25. The gallon had about ¾ of milk left in the bottle. The Lead Chef removed the expired gallon of milk and brought it to the attention of Dietary Aide #1. An interview with the Lead Chef on 7/7/25 at 11:15 AM revealed both nursing and the dietary aides were responsible for checking the nourishment refrigerators for expired food and drink items. The Lead Chef stated the nurse aides more frequently used the nourishment refrigerators if residents needed snacks or drinks. During an interview with Dietary Aide #1 on 7/7/25 at 11:18 AM, she stated that she had looked in the nourishment refrigerator, but she didn't really check the expiration dates on the food and drink items inside. She further stated that she had just came in at 10:00 AM, and that the nourishment refrigerator was supposed to be checked by Dietary Aide #2 who came in at 7:00 AM. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Dietary Aide #2 on 7/7/25 at 11:20 AM revealed she cleaned the nourishment station every morning before breakfast service, and she tried to check the food and drink items in the nourishment refrigerators as well. She stated that she didn't notice the expired gallon of milk inside the nourishment refrigerator, but she didn't think it got served to the residents this morning because they normally got the individual packs of milk. An interview with Nurse Aide #1 on 7/7/25 at 12:03 PM revealed the dietary aides normally gave them a heads up if any of the food and drink items in the nourishment refrigerators were expiring. She stated that she didn't look at the expiration date on the jug of milk before she poured some on a bowl of cereal and served it to one of the residents this morning. An interview with the Dietary Manager on 7/8/25 at 1:18 PM revealed both the dietary aides and nursing were supposed to check the nourishment refrigerators for expired food and drink items. An interview with the Administrator on 7/8/25 at 4:15 PM revealed she was not sure how the expired milk was left in the nourishment refrigerator, but it should have been discarded.