

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Willowbrook Rehabilitation and Care		STREET ADDRESS, CITY, STATE, ZIP CODE 333 East Lee Street Yadkinville, NC 27055	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interviews, the facility failed to ensure 1 of 1 sampled resident (Resident #76) attended his doctor appointment when Resident #76 missed a scheduled orthopedic appointment on 9/12/24 to have stitches removed due to facility failure to transcribe the order resulting in a missed doctor appointment. The findings included:Resident #76 was admitted to the facility on [DATE] with diagnosis including displaced subtrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing and anxiety.Resident # was discharged from the facility on 9/20/24. During an interview with Unit Manager #1 on 9/11/25 at 12:03 p.m. she revealed that Resident #76 missed his appointment to have his stiches removed on 9/12/24. She stated the DON received telephone orders on 9/6/24 but did not document the information. She further stated that as soon as they noticed the error on 9/19/24, they made Resident #76 an appointment. She stated that she did a wound assessment on Resident #76 on 9/19/24 and that the wound did not get infected and Resident #76 did not experience any harm. In an interview with the Director of Nursing (DON) on 9/11/25 at 3:44 p.m. she stated that Resident #76 missed an appointment for his stiches to be removed because she forgot to transcribe the order from Resident #76's doctor on 9/6/24. She stated she received the telephone order 9/6/24 to remove the stitches but did not transcribe it to the Treatment Administration Record (TAR) leading to Resident #76 missing his appointment on 9/12/24. The DON stated that she was responsible for the error of not transcribing the order and communicating to the nursing staff. She stated that when the error was discovered she contacted the doctor's office, and the resident was seen on 9/19/24. In a telephone interview with the prior Administrator on 9/12/25 at 9:17 a.m. She revealed that DON's failure to transcribe a telephone order for Resident #76 on 9/6/24 was responsible for Resident #76's missing his appointment on 9/12/24. The prior Administrator stated that the facility discovered the missed appointment on 9/19/24 when the doctor's office called the facility. She stated that the DON secured an appointment for Resident #76 to be seen on the same date. The prior Administrator further stated that lack of documenting in the TAR caused the error. She stated that a plan of correction was immediately implemented when the error was identified to ensure residents orders and appointments are transcribed correctly. The facility provided the following corrective action plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/19/24 Resident #76 went to his orthopedic appointment to have staples removed. Unit manager assessed the wound to ensure no signs and symptoms of infection ae present. Director of Nursing (DON) failed to put wound order into Point Click Care (PCC) causing transcript error. The admitting nurse failed to obtain wound care orders when doing initial assessment. -The facility recognizes that all residents who have wounds have the potential to be affected by the noncompliance failure to transcribe orders per the physician and not providing transportation to scheduled appointments for follow-up needs. On 9/19/24 an assessment and review of Resident #76's by the Unit manager found no evidence of trauma or infection. Or deterioration of the surgical wound. On 9/19/24 the Assistant Director of Nursing (ADON) re-educated nurses on contacting the Physician to obtain any wound orders on admission as indicated. On 9/19/24 the Regional Director of Nursing re-educated the DON on ensuring that when taking orders via telephone the orders are placed into PCC, and they are on the residents' Treatment record as indicated to prevent transcription errors.On 9/19/24, Regional Director of Clinical services completed a root cause analysis regarding the noncompliance of transcribing wound orders.Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 9/19/24 all residents are identified as having the potential to be affected for those who have wounds and follow up appointments. A quality review of 100% of current residents with wounds and scheduled appointments was audited by the Unit managers to ensure all residents who have wounds have orders in pace per physician and any follow-up appointments have transportation scheduled. On 9/19/24 the Unit managers re-educated nurses that when doing the initial skin assessments on all new admissions or readmissions that if there is any wounds to obtain an order for treatment and to place on the treatment record to ensure proper treatment is in place per physician orders and to place all needed follow up appointments in the transportation box to bring to clinical to ensure all appointments are scheduled and transportation is set up accordingly. Address what measures were put in place to ensure the deficient practice will not recur: On 9/19/24 the nursing managers re-educated all nurses when admitting a patient to ensure proper treatment is in place per physician order -Newly hired nurses will</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 31 medication administration opportunities resulting in a medication error rate 6.45% for 2 of 6 residents observed during medication pass (Resident #3 and Resident #41).The findings included:1.Resident #3 was admitted to the facility on [DATE] with diagnoses that included glaucoma.A review of Resident #3's active physician orders dated 7/3/25 included a current order for Dorzolamide HCL-Timolol Maleate Ophthalmic Solution 2-0.5% (a combination medication used to lower intraocular pressure in patients with open-angle glaucoma) one (1) drop to right eye twice a day. This medication was not administered to Resident #3 as ordered on 9/11/25.On 9/11/25 at 9:15 AM, Nurse #1 was observed as he prepared and administered 8 oral medications to Resident #3. Nurse #1 reported Resident #3's Dorzolamide HCL-Timolol Maleate Ophthalmic Solution 2-0.5% was not available on the medication cart for administration. Nurse #1 stated he would reach out to the pharmacy to reorder the medication.During an interview with Nurse #1 on 9/11/25 at 9:20 AM, he indicated he was unable to locate the medication in the medication cart. Nurse #1 was unable to indicate why the medication was not available. He stated he would follow up with the pharmacy to see if the medication could be sent with the next medication delivery. An interview was conducted with the Director of Nursing (DON)on 9/12/25 at 1:00 PM. The DON stated if a medication was not available for administration, the nurse should go to the Omnicell to see if the medication was there. The DON stated she expected that the nurse would notify the provider if a medication was missing and follow further instructions for the missed dose provided by the provider.2. A review of the manufacturer's instructions on the preparation for use of the Budesonide-Formoterol Fumarate Inhalation Aerosol inhaler was conducted. The instructions read, in part: Shake your Budesonide-Formoterol Fumarate Inhalation Aerosol inhaler well for 5 seconds right before each use. Remove the mouthpiece cover. Hold the Budesonide-Formoterol Fumarate Inhalation Aerosol inhaler up to your mouth and close your lips around it. Breathe in (inhale) deeply and slowly through your mouth. Press down firmly and fully on the top of the canister to release the medication. Shake the Budesonide-Formoterol Fumarate Inhalation Aerosol inhaler again for 5 seconds and repeat the above steps.Resident #41 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD).A review of Resident #41's active physician orders dated 6/26/25 included a current order for Budesonide-Formoterol Fumarate Inhalation Aerosol 80-4.5 MCG/AC inhale 2 puffs every 12 hours. Budesonide-Formoterol Fumarate Inhalation Aerosol is an inhaled medication containing a combination of budesonide and formoterol use for the management of COPD.On 9/12/25 at 8:50 AM, Nurse #2 was observed as she administered Budesonide-Formoterol Fumarate Inhalation Aerosol 80-4.5 MCG/AC to Resident #41. Nurse #2 retrieved the inhaler from the box and shook the inhaler for 5 seconds. Nurse #2 removed the mouthpiece and administered 2 puffs of medication without shaking the inhaler between puffs.An interview conducted with Nurse #2 on 9/12/25 at 8:57 AM revealed she had forgotten to wait and shake the inhaler between inhalations. The nurse stated she realized she should have waited and shook the inhaler between doses but just forgot.An interview was conducted with the Director of Nursing (DON) on 9/12/25 at 1:00 PM. The DON stated some of the newer combination inhalers did not require the nurse to wait 3 to 5 minutes between each puff of medication. The DON retrieved the manufacturer's instructions which stated in part the inhaler was to be shaken for 5 seconds, and a repeat inhalation administered. The DON stated she expected that the nurse would follow the manufacturer's instructions when administering inhalers.An interview was conducted with the Administrator on 9/12/25 at 1:49 PM. The Administrator stated she expected medications would be administered as ordered by the provider and manufacturer's instructions would be followed.</p>		