	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION		TE SURVEY MPLETED
		345113	B. WING			C
	ROVIDER OR SUPPLIER	040110		EET ADDRESS, CITY, STATE, ZIP CODE	1	1/30/2023
0.002 01 11						
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER	GO	LDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
E 000	Initial Comments		E 000			
F 000	investigation survey v through 11/30/23. Th compliance with the r	ertification and complaint vas conducted on 11/27/23 le facility was found in equirement CFR 483.73, ness. Event ID #XIQS11.	F 000			
	survey was conducte 11/30/23. Event ID# intakes were investig	complaint investigation d from 11/27/23 through XIQS11. The following ated NC00205596, 207856, NC00209049 and				
F 582 SS=F	deficiency.	int allegations resulted in overage/Liability Notice )(18)(i)-(v)	F 582			12/28/23
	§483.10(g)(17) The fa (i) Inform each Medic writing, at the time of facility and when the Medicaid of- (A) The items and se nursing facility service for which the resident (B) Those other items facility offers and for charged, and the amo services; and					
	changes are made to	the items and services g)(17)(i)(A) and (B) of this				
	§483.10(g)(18) The fa	acility must inform each				
	DIRECTOR'S OR PROVIDER/S			TITLE		(X6) DATE

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.

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/04/202 FORM APPROVE OMB NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113		B. WING		C 11/30/2023
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP (	CODE
WILLOW CREEK NURSING AND REHABILITATION CENTER			2401 WAYNE MEMORIAL DRIVE		
			GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 582	periodically during the available in the facility services, including ar covered under Medic facility's per diem rate (i) Where changes in and services covered Medicaid State plan, notice to residents of reasonably possible. (ii) Where changes at items and services the facility must inform th 60 days prior to imple (iii) If a resident dies facility must refund to representative, or est deposit or charges al per diem rate, for the resided or reserved of facility, regardless of discharge notice requ (iv) The facility must in	the time of admission, and e resident's stay, of services y and of charges for those hy charges for services not are/ Medicaid or by the e. coverage are made to items I by Medicare and/or by the the facility must provide the change as soon as is re made to charges for other at the facility offers, the e resident in writing at least ementation of the change. or is hospitalized or is not return to the facility, the o the resident, resident tate, as applicable, any ready paid, less the facility's days the resident actually or retained a bed in the any minimum stay or	F 5	82	
	date of discharge from (v) The terms of an a behalf of an individual facility must not confl these regulations. This REQUIREMENT by:	dmission contract by or on Il seeking admission to the ict with the requirements of is not met as evidenced			
	facility failed to provid	nced Beneficiary Notice of		F 582 Medicaid/Medicare Liability A new Advanced Beneficia	
		tet cost for care for 3 of 3		non-coverage (ABN)/ liabil	-

Facility ID: 923020

If continuation sheet Page 2 of 31

		ND HUMAN SERVICES				FOR	D: 01/04/202 MAPPROVE D. 0938-039
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345113	B. WING			C 11/30/2023	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		00.2020
				24	01 WAYNE MEMORIAL DRIVE		
WILLOW CREEK NURSING AND REHABILITATION CENTER				G	OLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 582	Continued From pag	e 2	F 5	82			
	residents reviewed for		1.5	02	given to Resident # 70 on 12-19-23 b	w tho	
	(Residents #70, #134				Social Worker containing estimated of		
		.,			of all out-of-pocket services. The		
	Findings included:				Administrator validated this on 12-19	-23.	
	5				A new Advanced Beneficiary Notice		
	a. Resident #70 was	admitted to the facility on			non-coverage (ABN)/ liability notice v	/as	
	9/26/23.				given to Resident #134 on 12-19-23	су	
					the Social Worker containing estimate		
		70's record indicated the			costs of all out-of-pocket services. The		
		/23 had no estimated out of			Administrator validated this on 12-19		
	•	documented on the form.			A new Advanced Beneficiary Notice of		
		ed in the facility with benefit			non-coverage (ABN)/ liability notice v		
	days remaining.				given to Resident #393 on 12-19-23 the Social Worker containing estimat	•	
	h Resident #134 wa	s admitted to the facility on			costs of all out-of-pocket services. The		
	10/19/23.				Administrator validated this on 12-19		
					On 12-19-23, an audit of all Medicare		
	Review of Resident #	134's record indicated the			discharges for the past 30 days was		
	SNF ABN dated 11/2	2/23 had no estimated out of			completed by the Business Office		
	pocket cost for care of	documented on the form.			Manager to ensure all Notifications of		
		ned in the facility with benefit			Medical Non-Coverage (NOMNC) we	ere	
	days remaining.				completed appropriately to include		
	D :1 ///000				providing estimated out of pocket cos		
		s admitted to the facility on			for all services. All areas of concern		
	11/9/23.				addressed by Business Office Managi include issuing appropriate notification		
	Review of Resident ±	#393's record indicated the			non-coverage with estimated costs of		
		1/23 had no estimated out of			services provided to the resident/resi		
		documented on the form.			representative.		
	•	ned in the facility with benefit			On 12-19-23 an in-service was initiat	ed by	
	days remaining.				the Administrator with the Accounts		
					Receivable and Social Workers rega	•	
		vith Social Worker #1 on			Notifications of Medical Non-Coverage		
		she indicated she had been			(NOMNC) with emphasis on providin	g	
		years and had never been			appropriate notification related to		
		mated out of pocket cost for			non-coverage of Medicare A resident		
		the SNF ABN. She further			include providing an estimated out of		
		came prefilled from the			pocket cost of all services. The in-ser		
	corporate office. She	indicated that the Social			will be completed by 12-21-23. All ne	wiy	

Facility ID: 923020

If continuation sheet Page 3 of 31

	TION NUMBER: 345113	A. BUILDING		COMPLETED	
(X4) ID PREFIX TAG       SUMMARY STATEMENT OF DE (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING         F 582       Continued From page 3 Work office was the only one to dis SNF ABN to Residents.         An interview with Social Worker #2 3:00 PM revealed she also was ur estimated out of pocket cost for ca be included on the SNF ABN. She that Social Work was the only offic the SNF ABN to Residents and tha prefilled from the facility Corporate During an interview with the Admir 11/30/23 at 1:30 PM, she indicated unaware that the estimated out of care was to be included on the SN	345113		A. BUILDING		
WILLOW CREEK NURSING AND REHABILITATION         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DE (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING         F 582       Continued From page 3 Work office was the only one to dis SNF ABN to Residents.         An interview with Social Worker #2 3:00 PM revealed she also was un estimated out of pocket cost for ca be included on the SNF ABN. She that Social Work was the only office the SNF ABN to Residents and that prefilled from the facility Corporate During an interview with the Admin 11/30/23 at 1:30 PM, she indicated unaware that the estimated out of care was to be included on the SNF		B. WING	C 11/30/2023		
(X4) ID PREFIX TAG       SUMMARY STATEMENT OF DE (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING         F 582       Continued From page 3 Work office was the only one to dis SNF ABN to Residents.         An interview with Social Worker #2 3:00 PM revealed she also was ur estimated out of pocket cost for ca be included on the SNF ABN. She that Social Work was the only offic the SNF ABN to Residents and tha prefilled from the facility Corporate During an interview with the Admir 11/30/23 at 1:30 PM, she indicated unaware that the estimated out of care was to be included on the SN			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PREFIX TAG       (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING         F 582       Continued From page 3 Work office was the only one to dis SNF ABN to Residents.         An interview with Social Worker #2 3:00 PM revealed she also was ur estimated out of pocket cost for ca be included on the SNF ABN. She that Social Work was the only offic the SNF ABN to Residents and tha prefilled from the facility Corporate During an interview with the Admir 11/30/23 at 1:30 PM, she indicated unaware that the estimated out of care was to be included on the SNF	ON CENTER				
<ul> <li>Work office was the only one to dis SNF ABN to Residents.</li> <li>An interview with Social Worker #2 3:00 PM revealed she also was un estimated out of pocket cost for cabe included on the SNF ABN. She that Social Work was the only offic the SNF ABN to Residents and that prefilled from the facility Corporate</li> <li>During an interview with the Admin 11/30/23 at 1:30 PM, she indicated unaware that the estimated out of care was to be included on the SNF</li> </ul>	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
	e on 11/30/23 at aware the re needed to further stated e to distribute t they came Office. istrator on she was pocket cost or F ABN and that	F 582	<ul> <li>hired Administrators, Accounts Receive Bookkeepers, and/or Social Workers we be in-serviced during orientation regard Notifications of Medical Non-Coverage (NOMNC).</li> <li>A 10% audit of all Medicare A discharg will be reviewed by the Business Office Manager weekly x 4 weeks then month 1 month utilizing the NOMNC Form Au tool to ensure the appropriate notificatio of medical non-coverage to include an estimated cost of all services was provided to the resident/resident representative with the appropriate boo checked and signature. The Social Worker and/or Accounts Receivable st will address all areas of concern identified. The Administrator will review the NOMNC Form Audit tool weekly x weeks then monthly x 1 month to ensu- all areas of concern were addressed. The Administrator will forward the NOMNC Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee month x 2 months. The QAPI Committee will meet monthly x 2 months and review the NOMNC Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or</li> </ul>	vill ding e les e hly x dit ion x x taff fied vill v 4 ure hly he s	
F 584 Safe/Clean/Comfortable/Homelike SS=D CFR(s): 483.10(i)(1)-(7)	Environment	F 584	frequency of monitoring.	12/28/23	

Facility ID: 923020

If continuation sheet Page 4 of 31

STATEMENT OF DEPICIENCES AND PLAN OF CORRECTION       (X) DENTIFICATION NUMBER: JAST13       (X) MULTIPLE CONSTRUCTION A BUILDING       (X) DATE SUPPLY A BUILDING         NAME OF PROVIDER OR SUPPLIER       345113       ITTEET ADDRESS, OTT, STATE, 2P CODE 201 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27531         WILLOW CREEK NURSING AND REHABILITATION CENTER REGULATORY OR LSC IDENTIFYING INFORMATION;       ITTEET ADDRESS, OTT, STATE, 2P CODE 201 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534         OWID PREFIX TAG       JUNNAWY STATEMENT OF DEFICIENCES (EACH OPERCENT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (M) O EACH OPERCENT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 584       Continued From page 4 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.       F 584         The facility must provide- §483.100()(1) A safe, clean, comfortable, and homelike environment, allowing the resident to independence and dece not poes a safety risk. (i) The facility must provide- §483.100()(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;       §483.100()(3) Clean bed and bath linens that are in good condition;       §483.100()(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); sl483.100()(6) Comfortable lighting levals in all areas; sl483.100()(6) Comfortable and safe temperature		-	D HUMAN SERVICES				FORM	D: 01/04/2024 MAPPROVED D. 0938-0391
346113         B. WING         11/30/2023           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STREE, ZPI CODE         2401 WAYKE MEMORIAL DRIVE GOLDSBORO, NC 27534         D           (Y4) JD PREETK TAG         EACH OFFICIENCIES (EACH OFFICIENCY MAST BE RECEDED BY TULL RECOLLINGY OR LSC DENTIFYING INFORMATION)         D         PROVIDER ACTION SHOULD BE CONSERVENCE OF DO FROMETING INFORMATION)         DO PREETK TAG         CONSECUTION (EACH OFFICIENCY MAST BE RECEDED BY TULL RECOLLINGY OR LSC DENTIFYING INFORMATION)         D         PREETK CONSERVENCE OF DO FROMETING INFORMATION)         D         CONSECUTION (CONSECUTION TAG         D         CONSECUTION (CONSECUTION TAG         D         CONSECUTION (CONSECUTION (CONSECUTION TAG         D         CONSECUTION (	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · ·			(X3) DATE COMP	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY STRE. 21P CODE       WILLOW CREEK NURSING AND REHABILITATION CENTER     2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534       PAUD PRETEX TAG     SUMMARY STREMENT OF DEFICIENCIES (EACH DEPROLEVY MUST ER PROCEEDED BY PULL RECOLLOTORY OR LSC DENTIFYING INFORMATION)     ID PRETEX RECOLLOTORY OR LSC DENTIFYING INFORMATION)     PROVIDER CORRECTION (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     ID OURSECTION (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 584     Continued From page 4 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.     F 584       The facility must provide- §483.10(1)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.     F 10 fracility shall exercise reasonable care for the protection of the resident's property from loss or theft.       §483.10(1)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(1)(3) Clean bed and bath linens that are in good condition;       §483.10(1)(4) Private closet space in each resident nom, as specified in §483.90 (e)(2)(iv); §483.10(1)(6) Comfortable inghting levels in all areas; §483.10(1)(6) Comfortable and safe temperature			345113	B. WING		_		
MILLOW CREEK NURSING AND REHABILITATION CENTER         GOLDSBORO, NC 27534           (PA) ID PRETIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH ORRECTIVA ACTION STRUCTORY UNCLOCATION)         ID PRETIX (EACH ORRECTIVA ACTION STRUCTORY UNCLOSE DENTIFYING INFORMATION)         ID PRETIX TAG         PRETIX (EACH ORRECTIVA ACTION STRUCTORY UNCLOSE DENTIFYING INFORMATION)         ID PRETIX TAG         PRETIX (EACH ORRECTIVATION DESCRIPTION UNCLOSE DENTIFYING INFORMATION)         ID PRETIX TAG         PRETIX (EACH ORRECTIVATION CONSERVENTION OF CONSERVENTION OF CONSERVENTION (EACH ORRECTION NUCLEA CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         (ID OTHER (EACH ORRECTION THE APPROPRIATE DEFICIENCY)         (ID OTHER (EACH ORRECTION UNCLEASE (EACH ORRECTION OR CONSERVENTION OF CONSERVENTION OF CONSERVENTION (EACH ORRECTION THE APPROPRIATE DEFICIENCY)         (ID OTHER (EACH ORRECTION THE APPROPRIATE DEFICIENCY)         (ID OTHER (EACH ORRECTION OR (EACH ORRECTION OR (I) The facility indig safely.         ID (I) The facility maximizes resident independence and desen to pose a safely and that the physical layout of the resident's property from loss or theft.         §483.10(1)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;         §483.10(1)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(V));         §483.10(1)(6) Comfortable and safe temperature         ID (I) (I) (I) (I) Comfortable and safe temperature <td>NAME OF PF</td> <td>ROVIDER OR SUPPLIER</td> <td></td> <td>s</td> <td>STREET ADDRESS, CITY, ST</td> <td>TATE, ZIP CODE</td> <td></td> <td></td>	NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PREFIX TXG     (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR US O DENTIFYING INFORMATION)     PREFX TXG     (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)     COMMENT DEFICIENCY       F 584     Continued From page 4 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.     F 584     F 584       The facility must provide- §483.10()(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.     If the resident to use his or her personal belongings to the extent possible.     If the resident to use his or her personal belongings to the extent possible.     If the facility must provide- §483.10()(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10()(3) Clean bed and bath linens that are in good condition; §483.10()(5) Adequate and comfortable lighting levels in all areas; §483.10()(6) Comfortable and safe temperature     If the facility facility means are the present of the facility faci	WILLOW	CREEK NURSING AND R	EHABILITATION CENTER					
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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B		COMPLETION
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.	F 584	The resident has a rig comfortable and home but not limited to rece supports for daily livin The facility must prov §483.10(i)(1) A safe, of homelike environmen use his or her person possible. (i) This includes ensur receive care and serv physical layout of the independence and do (ii) The facility shall ex the protection of the ri- or theft. §483.10(i)(2) Houseke services necessary to and comfortable interior §483.10(i)(3) Clean bo in good condition; §483.10(i)(4) Private of resident room, as spec §483.10(i)(5) Adequar levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain a 81°F; and §483.10(i)(7) For the	<pre>ht to a safe, clean, elike environment, including iving treatment and g safely. ide- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can ices safely and that the facility maximizes resident es not pose a safety risk. kercise reasonable care for esident's property from loss eeping and maintenance maintain a sanitary, orderly, for; ed and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); te and comfortable lighting able and safe temperature ly certified after October 1, temperature range of 71 to</pre>	F 584				

If continuation sheet Page 5 of 31

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		10. 0938-03 FE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		G	. ,	MPLETED	
						С	
		345113	B. WING		1	1/30/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
		REHABILITATION CENTER		1			
WILLOW	CREEK NORSING AND P	CENTER CENTER	GOLDSBORO, NC 27534				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JENCY)	(X5) COMPLETIC DATE	
F 584	Continued From page	e 5	F 5	84			
		Γ is not met as evidenced					
	by:						
		on, resident interview, and		F 584 Safe/Clean/Com	nfortable/Homelike		
	staff interview the fac	ility failed to maintain walls		Environment			
	and resident beds in			On 12-19-23, the footbo			
4  -  -		m # 104, 105, 106, 111, 301		104-A was re-attached	,		
	· ·	r provision of a safe, clean,		the Maintenance Direct			
	homelike environmer	11.		administrator observation On 12-19-23, the head			
	The findings included	1.		replaced in Room 104-			
	•	was observed on 11/27/23		Maintenance Director a	-		
	at 11:32 AM. During the observation it was			administrator observati	•		
	revealed the footboar			On 12-19-23, the drywa	all in Room 105-A		
	disconnected from th	e bed. It was resting		was repaired by the Ma	aintenance Director		
		frame of the bed which		and verified by adminis			
		the resident if it fell onto the		On 12-19-23, the drywa			
	Resident's feet while	in bed.		was repaired by the Ma and verified by adminis			
	A second observatior	n of Room #104 bed A was		On 12-19-23, the drywa			
	made on 11/30/23 at			Room 111-B by the Ma			
		r. The observation revealed		and verified by adminis			
	the footboard of bed			On 12-19-23, the drywa			
	disconnected and res	sung on the frame.		Room 301 by the Maint and verified by adminis			
	Room #104 bed B wa	as observed on 11/27/23 at		On 12-19-23, the drywa			
		observation it was revealed		Room 602 and the hea	-		
		oard was damaged in one		re-attached to bed by the	-		
		ece was being held on by		Director and verified by			
	clear office tape.			observation.			
				On 12-1-23, the Mainte			
		n #104 bed B stated she had		under the oversight of t			
		pard to be repaired or		initiated an audit of all r			
		months ago and had not		include rooms 104, 105			
		She stated she had put the with strips of clear office		and 602. This audit was identify any room that r	-		
	tape in the meantime			include, but not limited			
				broken headboard, and			
	A second observatior	n of Room #104 bed B was		to maintain a safe and			
	made on 11/30/23 at	12:30 PM with the		environment. The Admi	inistrator will		

Facility ID: 923020

If continuation sheet Page 6 of 31

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				RM APPROVE 10. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
		345113	B. WING		C 11/30/2023	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW CREEK NURSING AND REHABILITATION CENTER						
				GOLDSBORO, NC 27534	FOTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 584	Continued From page	e 6	F 58	4		
	a piece of broken hea clear office tape. B. An observation of 1 11/27/23 at 12:30 PM wall at the head of the torn away and there w drywall visible. A second observation 11/30/23 at 9:10AM re damage to the wall at the wallpaper was tor scratches with drywal C. An observation of 11/27/23 at 12:34 PM and peeling along the Drywall was visible w 3 feet long and 3 inch A second observation 11/30/23 at 9:15 AM re	I revealed damage to the e bed where wallpaper was were deep scratches with n of Room #105 bed A on evealed no change in the t the head of the bed where in away and there were deep II visible. Room #106 bed A on I revealed wallpaper missing wall at the side of the bed. ith scratches approximately hes wide. n of Room #106 bed A on revealed the damaged wall h missing and peeling scratches.		<ul> <li>address all concerns identified of audit to include, but not limited to repairing damaged walls, painting replacement of wallpaper when and/or repair/replace damaged headboards and footboards. The be completed by 12/28/23. The Maintenance will provide the Ad a schedule for completion of all concern identified.</li> <li>On 12-1-23, the Administrator of an in-service with the Maintenance staff of Maintaining a Safe and Homelikk Environment with emphasis on the repair of facility and resident room maintain a safe and homelike environment and not resolving worders in TELs system until repair completed.</li> <li>On 12-1-23, the Staff Developm Coordinator (SDC) initiated an in with all nurses, nursing assistant staff, housekeeping staff, mainter staff, accounts payable, account receivable, social worker, adminatical records director regarditional concernity staff, receptionist, sched medical records director regarditional concernity and resident records director regarditional concernity staff, receptionist, sched medical records director regarditional concernity director regarditional concernity staff, receptionist, sched medical records director regarditional concernity director regarditical concernity dire</li></ul>	o, ng or indicated, e audit will ministrator areas of ompleted nce regarding e timely oms to vork airs are ent n-service ts, therapy enance ts istrator, uler, and	
	11/27/23 at 12:40 PM	l revealed peeling and d gouges in drywall behind arge area of missing		and Homelike Environment. Em placed on the process for promp reporting of any area in the facil of repair to maintain a safe and environment to include but not li peeling wallpaper/paint, damage	phasis ot ity in need homelike mited to	
	11/30/23 at 9:20 AM r change in the condition	n of Room #111 bed B on revealed there was no on of the damaged walls with wallpaper and scratched		unattached headboards/footboa damaged drywall in resident roo in-service will be completed by After 12-28-23, any staff who ha received the training will completed	rds, and oms. The 12-28-23. as not	

Event ID: XIQS11

Facility ID: 923020

If continuation sheet Page 7 of 31

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/04/2024 MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		345113	B. WING				C / <b>30/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				24	401 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND R	REHABILITATION CENTER		G	OLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	Continued From page	e 7	F	584			
	<ul> <li>E. An observation of on 11/27/23 at 12:10 measuring about 1 x was scratched off and gouged.</li> <li>The Resident in room 12:10 PM the deep g of her bed had been to indicated she had as fixed and stated she had as second observation at 9:40 AM revealed to to the right of the bed missing wallpaper an</li> <li>In an interview with N at 10:00 AM it was re- orders were to be ent maintenance request any employee could p</li> <li>An interview with Nur AM revealed she put into the facility mainter further stated she wo televisions not workin working properly.</li> <li>An interview with the 10:20 AM revealed st requests into the facili system. The Unit Mar</li> </ul>	Room #301 (private room) PM revealed a circular area 1 foot where the wallpaper d the drywall was deeply a #301 stated on 11/27/23 at ouge in the wall to the right there for at least a year. She ked staff about having it had received no response. In of room #301 on 11/30/23 no change in damage to wall I. There continued to be d gouged drywall. Iurses Aide #1 on 11/30/23 vealed all maintenance work tered into the facility system. She further stated put in a request. Se #1 on 11/30/23 at 10:08 all maintenance work orders enance request system. She uld enter requests such as ng, water leaks or beds not Unit Manager on 11/30/23 at taff would put maintenance lity maintenance request hager stated that there used staff, but they had lost one			in-service on the next scheduled work shift. All newly hired nurses, nursing assistants, therapy staff, housekeepin staff, maintenance staff, accounts payable, accounts receivable, social worker, administrator, activity staff, receptionist, scheduler, and medical records director will be in-serviced dur orientation regarding Maintaining a Sa and Homelike Environment. The Administrator will complete facility rounds to include all resident rooms to a week x 4 weeks then monthly x 1 m utilizing the Environmental Rounds Au Tool. This audit is to identify any area the facility in need of repair to include not limited to damaged walls, damage unattached headboards/footboards, and/or areas in need of painting to maintain a safe and homelike environment. Staff that identify an are concern will place work order in TELS which will notify the maintenance direr and/or assistant medical director for a identified areas of concern and notify Maintenance Director. The Maintenan Director will address all work orders submitted for concerns identified to include but not limited to repairing, painting walls, replacing drywall, and/or replacing broken or unattached headboards and footboards. The Administrator will review the Environmental Rounds Audit Tool wee x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The Administrator will present the find	ring afe / vice onth udit in but ed or a of ctor II the ce Dr	
	An interview with the	Maintenance Manager on			of the Environmental Rounds Audit To	-	

Facility ID: 923020

TATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	<b>IPLETED</b>
		345113	B. WING			С
	ROVIDER OR SUPPLIER	345115		STREET ADDRESS, CITY, STATE, ZIP CODE		1/30/2023
	NOWDER OR SOLT EIER			2401 WAYNE MEMORIAL DRIVE		
WILLOW CREEK NURSING AND REHABILITATION CENTER				GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 584	Continued From page		F 584			
	maintenance request request system, and real time. Maintenance for issues, they rely of further stated he was the walls in some roo they lost recently was He further stated they	12:30 PM revealed he received e requests through the maintenance tem, and it appeared on his phone in aintenance does not inspect rooms hey rely on the request system. He d he was aware of the condition of some rooms. The maintenance staff tently was the one who fixed the walls. tated they were not currently looking aintenance staff person until the		the Quality Assurance Perform Improvement (QAPI) committee for 2 months. The QAPI Comm meet monthly for 2 months and Environmental Rounds Audit T determine trends and/or issues need further interventions put and to determine the need for frequency of monitoring.	e monthly nittee will d review the cool to s that may into place	
	11/30/23 at 11:08 AM maintenance work re- the facility maintenan staff member. She fu lost a maintenance w She was unaware if t replace him. F. Room 602 was obs 11:59am. The observ indented lines on the bed that revealed pla headboard to his bed be attached on one s	quests would be entered into ce request system by any rther stated that the facility orker about 3 months ago. he facility was trying to served on 11-27-23 at ation revealed 4 linear wall behind the resident's ster. The resident's was also observed to only ide allowing the headboard ely which could cause injury ied to hold onto the				
	8:53am with the Main observation revealed the wall behind the re plaster and the reside	a occurred on 11-29-23 at atenance Director. The 4 linear indented lines on esident's bed that revealed ent's headboard to his bed only be attached on one				

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 01/04/202 MAPPROVE D. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345113	B. WING			30/2023
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW CREEK NURSING AND REHABILITATION CENTER				401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	discussed the damag stated he was aware explained the mainte handed and they wer when they had a cha Director examined th his bed, he stated the screw. He said he wa headboard and expla maintenance issues i	The Maintenance Director le to room 602's wall and the wall needed repair. He nance department was short e trying to repair the walls nce. When the Maintenance e resident's headboard on e headboard had lost a as not aware of the loose ined staff would report n their computer system and staff had not reported the	F 584			
F 677 SS=D	2:40pm. The Adminis maintenance departm confirmed staff reque through their compute was aware of the new resident's wall but wa headboard. The Adm loose headboard cou resident if he attempt while repositioning in ADL Care Provided for	nent being short-staffed and sted maintenance repairs er system. She stated she ed for repairs to the us unaware of the loose inistrator discussed the Id cause injury to the ed to grab the headboard the bed. or Dependent Residents	F 677			12/28/23
	out activities of daily services to maintain of personal and oral hyd This REQUIREMENT by: Based on record rev interviews the facility incontinence care on	is not met as evidenced iew, observation, and staff		F 677 ADL Care Provided for Dependent Residents On 11-29-23, the Director of Nursing assessed Resident #24 to ensure		

Event ID: XIQS11

Facility ID: 923020

If continuation sheet Page 10 of 31

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(¥3) DA	TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED	
						С	
		345113	B. WING	1	1/30/2023		
NAME OF PF	ROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZIP COD	E		
WILLOW CREEK NURSING AND REHABILITATION CENTER				GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
F 677	Continued From page	e 10	F 67	7			
		prevent the likelihood of an		incontinent care had been pro	ovided in a		
	infection. Resident #2			manner to prevent the likeliho			
	Activities of Daily Livi	ng (ADL) care.		infection. There were no conc	erns		
				identified.			
	Findings included:			On 11-29-23, NA #1 was edu			
				regarding correct technique w			
		mitted to the facility on		incontinent care to include wi			
	dementia.	diagnoses that included		back to prevent infection. A s return demonstration during r			
	dementia.			was completed by NA #1 as c			
	The quarterly Minimu	m Data Set (MDS) dated		validated by the Director of N			
		sident #24 was severely		On 11-29-23, the Staff Develo			
	cognitively impaired a	and required extensive		Coordinator initiated an audit			
		person for toileting, bed		assistants to ensure residents	s were		
	mobility and personal	l hygiene.		provided incontinent care usin	•		
				correct technique, wiping from			
		blan dated 11-21-23 revealed nary incontinence related to		prevent the likelihood of an in			
		The goal for Resident #24		Staff Development Coordinate address all concerns identifie			
	included to be free of			audit to include providing inco	-		
		ventions for the goal were to		using the correct technique o			
		ene and receive peri care		to back and education of the			
	after each incontinent	t episode.		audit will be completed by 12	-28-23.		
				On 11-29-23, the Director of N	-		
		are occurred on 11-29-23 at		initiated an in-service with all	-		
	-	Assistant (NA) #1. Resident		assistants regarding Incontine			
		ved to be intact with no observed cleaning Resident		including using correct techni prevent the likelihood of infec			
		NA cleaned Resident #24's		in-service will be completed b			
	peri area from back to			After 12-28-23, any nursing a	•		
				has not worked or received th			
	During an interview w	/ith NA #1 on 11-29-23 at		will complete upon next schee	duled work		
		issed having to ask another		shift. All newly hired nursing a			
		y of cleaning a woman's peri		be in-serviced during orientat	-		
		d not remember, and they		Staff Development Coordinate			
		to front." NA #1 also stated		regarding Incontinent Care to			
		ned the peri area from front		successful return demonstrat	ion of correct		
	vaginal cavity.	use bacteria to enter the		incontinence care technique.			

Facility ID: 923020

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	ECONSTRUCTION	OMB NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
			-	С	
		345113	B. WING	11/30/2023	
IAME OF PI	ROVIDER OR SUPPLIER	•			
			:	2401 WAYNE MEMORIAL DRIVE	
	ILLOW CREEK NURSING AND REHABILITATION CENTER			GOLDSBORO, NC 27534	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETI
F 677	Continued From page	e 11	F 677		
				Resident Care Incontinent Audits on	
		nt Coordinator (SDC) was		residents who are incontinent to inclu	
		-23 at 9:49am. The SDC		Resident #24 weekly x 4 weeks, ther	
		w NA was hired, the NA		monthly x 1 month. Audits will include	
	would spend two day			shifts and all days of the week. This	
		ce care and then the NA on the skill of incontinence		is to ensure all residents with incontin	
		or. She also explained that		are provided incontinent care timely. Unit Managers will address all conce	
		or audits on the NAs to		identified during the audit to include	1115
		que was being used when		providing incontinent care when indice	ated
		peri area. The SDC stated		and re-education of the staff. The Di	
		education on incontinence		of Nursing will review the Resident C	are
	care and did not know	v why he would have used a		Incontinent Audits weekly x 4 weeks,	
	back to front cleaning	technique on Resident #24.		monthly x 1 month to ensure all area concern are addressed.	s of
	An interview with the	Director of Nursing (DON)		The Administrator will present the fin	dinas
		-29-23 at 2:13pm. The DON		of the Resident Care Incontinent Auc	-
	discussed NA #1 beir	-		the Quality Assurance Performance	
		d she would have expected		Improvement (QAPI) committee mon	thly
	the NA to clean Resid	lent #24's peri area from		for 2 months. The QAPI Committee v	vill
	front to back.			meet monthly for 2 months and revie	w the
				Resident Care Incontinent Audits to	
		s interviewed on 11-29-23 at		determine trends and/or issues that r	
		trator stated she believed		need further interventions put into pla	
		uring the observation and woman's peri area correctly.		and to determine the need for further frequency of monitoring.	
		ed residents to be cleaned			
	-	ing incontinence care.			
F 688 SS=D	Increase/Prevent Dec	crease in ROM/Mobility	F 688		12/28/23
	§483.25(c) Mobility.	cility must ensure that a			
		he facility without limited			
		not experience reduction in			
		ss the resident's clinical			
		es that a reduction in range			
	of motion is unavoida	5	1		

Facility ID: 923020

If continuation sheet Page 12 of 31

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED
		345113	B. WING_				C 30/2023
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				24	401 WAYNE MEMORIAL DRIVE		
WILLOW	REEK NURSING AND R	EHABILITATION CENTER		G	OLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page	9 12	F6	688			
	§483.25(c)(2) A reside motion receives appro- services to increase re- prevent further decrease §483.25(c)(3) A reside receives appropriate a assistance to maintain the maximum practical reduction in mobility is This REQUIREMENT by: Based on record revi- interviews, the facility on the left and right has	ent with limited range of			F 688 Increase/Decrease in ROM/Mobility On 11/30/23, Resident #3 was evaluate by Occupational Therapy for bilateral hand contractures and use of palm		
	Resident #3 was admitted to the facility on 5-31-12 with multiple diagnoses that included ight hand contracture. The quarterly Minimum Data Set (MDS) dated 0-20-23 revealed Resident #3 was severely cognitively impaired. Resident #3's care plan dated 10-6-23 did not nave any goals or interventions for palm guards. An observation of Resident #3 occurred on 11-27-23 at 11:20am. Resident #3's right and left nand were observed to be contracted with no balm guards present. Another observation of Resident #3 occurred on 11-28-23 at 4:00pm. The observation revealed here were no palm guards placed on the esident's left or right hand				guards. On 12/7/23, the Unit Managers completed an audit of all residents in the facility to assess for contractures. This audit was completed to ensure any resident identified with one or more contractures had interventions in place to prevent further decrease in range of motion to include palm guards, splints, and/or therapy recommendations as appropria No further concerns were identified. On 12/7/23, the Staff Development Coordinator initiated an audit of all Nursing Functional Maintenance Progri referrals for the past 30 days to treat contractures. This audit is to ensure caplans are updated for contracture	s ate.	
	resident's left or right				interventions including palm guards an	d	

Facility ID: 923020

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/04/2024 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345113	B. WING				C / <b>30/2023</b>
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				2401 WAYNE MEMORIAL DRIVE			
WILLOW	REEK NURSING AND R	REHABILITATION CENTER		G	OLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From page	e 13	F	688			
					splint/contracture devices are worn as	6	
	Resident #3 was obse				ordered/recommended by therapy.		
		was observed laying in the					
	bed without palm gua	ards to her left or right hand.			On 12/18/23, the Staff Development		
	<b>D</b> · · · · ·				Coordinator in-serviced certified nursi	•	
	-	vith Nursing Assistant (NA)			assistants and minimum data set nurs	ses	
		I2am, the NA discussed esident #3 and being aware			are responsible for carrying out the program regarding the referral proces	e for	
	•	ractures to her left and right			the Nursing Functional Maintenance	5 101	
		d Resident #3 had braces			Program to include ensuring care pla	าร	
		out 2 years ago" and stated			are updated for contracture intervention		
		ths" Resident #3 had not			including palm guards and splint/		
	had any braces or pa	Im guards to her left and			contracture devices are worn as		
	right hands.				ordered/recommended by therapy. The		
					in-service will be completed by 12/28/		
		ewed on 11-29-23 at 8:46am.			All newly hired certified nursing assist		
		being familiar with Resident			and minimum data set nurses will rec		
		ident "used to" have palm			training during orientation by the Staff		
		l right hands. Nurse #1 t know why Resident #3 no			Development Coordinator (SDC).		
	-	guards. She said she tried to			On 12/18/23, an in-service was initiat	-d	
		the NAs to place a rolled			by the Staff Development Coordinator		
		at #3's hand to prevent her			(SDC) for all nurses and nursing		
		o the palms of her hands.			assistants on "Observation and Repo	rting	
	- •				of Contractures during Resident Care	•	
		vas interviewed on 11-29-23			resident observed with contractures the		
		ab Director explained			does not have a splint, palm guard, o		
	Resident #3 had last				intervention in place must be reported		
		e further explained Resident			immediately to the supervisor and/or		
		storative services to continue			Director of Nursing (DON)." The in-se	IVICE	
	working on the reside	hab Director stated at the			will be completed by 12-28-23. After 12-28-23, any staff member that has	not	
		rehab services, the resident			received the in-service will be educate		
	was ordered bilateral				prior to the next scheduled shift. All n		
		ative program switching to a			hired nurses and nursing assistants w	-	
	functional maintenan				receive the in-service during orientation		
		ted Resident #3 should have			the Staff Development Coordinator (S		
		es. The Rehab Director said					
	Resident #3 had "falle	en through the cracks."			All Nursing Functional Maintenance		

Facility ID: 923020

If continuation sheet Page 14 of 31

TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DAT	O. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		245442				С
		345113	B. WING		1'	/30/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW	CREEK NURSING AND R	REHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETIC
F 688	Continued From page	e 14	F 68	8		
	An interview with the Staff Development Coordinator (SDC) occurred on 11-29-23 at 11:02am. The SDC confirmed she was responsible for coordinating the residents from the restorative program to the functional maintenance program. The SDC explained when the restorative program was changed to the functional maintenance program, Resident #3 should have been referred to therapy for an evaluation. She further explained the MDS nurses were responsible for making the referral to the therapy department.			Program referrals will be monitor Staff Development Coordinator weekly x 4 weeks, then once we month utilizing the Functional Maintenance Referral Monitorin This monitoring audit will be cor ensure all referrals to the Nursin Functional Maintenance Progra completed with care plans upda contracture interventions includ guards and splint/contracture de worn as ordered/recommended therapy. Any concerns identifie the audit will be addressed imm	5 times beekly x 1 g tool. npleted to ng m are ted for ng palm evices are by d during ediately by	
	11-29-23 at 11:16am, that she had never re Resident #3 on the re September 2022, so #3 needed a referral	vith MDS Nurse #1 on , the MDS Nurse explained eceived an order to place estorative program back in she was unaware Resident to therapy when the program onal maintenance program.		the Staff Development Coordina include providing additional train needed. The DON will review th Functional Maintenance Referra Monitoring tool weekly x 4 week monthly x 1 month for completion	ning as e al s, then on.	
	The Director of Nursing (DON) was interviewed on 11-29-23 at 2:02pm. The DON discussed the restorative program changing to the functional maintenance program but stated she did not know when that occurred. She discussed managers and department heads having a meeting each morning and talking about what residents were being released from therapy and if the resident would be placed on the functional maintenance program. The DON stated she could not remember if Resident #3 had been discussed and was unaware Resident #3 had not been receiving services.			The DON will present the finding Functional Maintenance Referra Monitoring tool to the Executive Assurance Performance Improv (QAPI) committee monthly for 2 The Executive QAPI Committee monthly for 2 months and review Smoking Audit Tool to determine and/or issues that may need fur interventions put into place and determine the need for further fit of monitoring.	al Quality ement months. will meet w the trends ther to	
	11-29-23 at 2:25pm,	vith the Administrator on the Administrator discussed g with management and the				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					/ APPROVE ). 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		345113	B. WING			C 11/30/2023		
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
WILLOW		REHABILITATION CENTER		24	401 WAYNE MEMORIAL DRIVE			
WILLOW	CREEK NORSING AND P	CERTABLE TATION CENTER		G	OLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 688	being released from t would need to follow program. She stated #3 had no longer bee would have expected services through the	talk about the residents therapy and if the resident the functional maintenance she was unaware Resident en receiving services and I Resident #3 to receive functional maintenance	F	688				
F 689 SS=E	Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(1) The re as free of accident ha §483.25(d)(2)Each re	ards/Supervision/Devices (2) s.	F	689			12/28/23	
	accidents. This REQUIREMENT by: Based on observation resident and staff inter- ensure that smoking staff for three of three observed for acciden #107, and Resident # Findings included: The facilities smoking man secured area and we the assistance of the Residents ability to star	T is not met as evidenced on, record review, and erviews, the facility failed to materials were secured by e sampled residents ts (Resident #101, Resident #119). g policy dated 2019 stated all terials were maintained in a ere accessible only through facility staff. Assessment of moke in a safe manner smoking in designated			F 689 Free of Accident Hazards/Supervision/Devices On 12/18/23, Resident #101 was educated by the administrator regardin 1) Storage of Smoking Materials (2) Designated Outside Smoking Areas/tin (3) Policy Violations with all residents smoke. All smoke materials were removed and secured per facility proto On 12/18/23, Resident #107 was educated by the administrator regardin 1) Storage of Smoking Materials (2) Designated Outside Smoking Areas/tin (3) Policy Violations with all residents smoke. All smoke materials were	mes that ocol. ng mes		

Event ID: XIQS11

Facility ID: 923020

If continuation sheet Page 16 of 31

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB I	NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		345113	B. WING			C 1/30/2023
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CO		
				2401 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND R	REHABILITATION CENTER		GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From page	e 16	F 68	9		
	reassessed at least n	nonthly utilizing the Smoking		removed and secured per fa	acility protocol.	
	<ul> <li>reassessed at least monthly utilizing the Smoking Evaluation by a Licensed Nurse. The interdisciplinary team would review the care plans of smokers and update based on the Smoking Evaluation.</li> <li>1. Resident #101 was admitted to the facility on 6/28/23 with diagnoses that included Hemiplegia (one sided weakness), Seizure disorder and Diabetes Mellitus II.</li> <li>A review of the care plan dated 10/26/23 revealed that Resident #101 was an independent and safe smoker of cigarettes. The goal was for the Resident to continue to smoke safely in designated areas and would continue to use smoking materials safely through the next review. Interventions included staff assistance obtaining smoking materials from a secured storage area upon request, evaluate resident's continued ability to smoke safely on a consistent and regular basis, and for staff to observe for potential</li> </ul>			On 12/18/23, Resident # 11 educated regarding 1) Stora Smoking Materials (2) Desig Outside Smoking Areas/tim Violations with all residents All smoke materials were re- secured per facility protocol On 11/30/23, the Administra audit of all residents who sr smoking paraphernalia. Thi identify any resident in pose smoking material that was r facility protocol. The Unit M address all concerns identif audit to include removing sr paraphernalia from resident storing smoke paraphernali protocol and education of th The audit will be completed On 11/30/23, the Administra	age of gnated es (3) Policy that smoke. emoved and ator initiated an noke for s audit is to session of not stored per anagers will ied during the moke t care areas, a per facility ne resident. by 12/28/23.	
	staff were to docume Administrator and/or provide education on resident. Resident #101's smo 11/3/23 indicated the and may smoke in de supervision. A review evaluations revealed monthly since admiss 2023.	king evaluation dated Resident was a safe smoker esignated areas without of the Resident's smoking they were performed sion to the facility in June		in-service with all residents regarding the smoke policy Storage of Smoking Materia Designated Outside Smokin Policy Violations. The in-sec completed by 12/28/23. On 11/30/23, the Staff Deve Coordinator initiated an in-s facility staff regarding Monit Paraphernalia to include (1) ensure all smoke parapherr returned immediately upon facility (2) Staff should repo	who smoke to include (1) als (2) ng Areas (3) rvice will be elopment service for all soring Smoking ) Staff should nalia is return to the rt to the	
	the smoking area on	bserved walking alone out to 11/28/23 at 8:25 AM without ox area. He then removed		assigned nurse, nurse supe Director of Nursing, or Adm immediately for any concern	inistrator	

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If continuation sheet Page 17 of 31

		MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY MPLETED
						С
		345113	B. WING			1/30/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
WILLOW	CREEK NURSING AND R	REHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE THE APPROPRIATE	COMPLETIO
F 689	Continued From page	e 17	F 68	99		
		om his front shirt pocket and		smoke safety or any resid	dent who has	
	proceeded to light a c			smoke paraphernalia that		
		-		properly. This in-service		
		Resident #101 on 11/28/23 at		by 12/28/23. After 12/28/2	23, any staff who	
		he smoked several times a		has not worked or comple		
		there were lock boxes for		in-service will complete p		
		eir smoking materials in, and		scheduled work shift. All	•	
		hat was kept by the Resident		will be in-service during o	•	
		e was unaware if staff knew materials on his person.		Staff Facilitator regarding Smoking Paraphernalia.	Monitoring	
		natenais on his person.		The Quality Assurance N	urse Staff	
	An observation of the	smoking area on 11/30/23		Development Coordinato		
		I metal shelving with lock		Social Worker and Activit	-	
	boxes secured to the	shelves. Each box was		complete observations of	smoke sessions	
	individually numbered	d.		two times a week x 4 wee		
				1 month using the Smoke		
		sing Assistant (NA) #1 on		Audit Tool. This audit is to		
	11/30/23 at 9:30 AM			residents return smoke p		
		ibited from keeping smoking son or in their rooms. She		the end of each smoke se smoke paraphernalia is s		
		re Resident #101 kept his		per facility protocol. The	-	
	smoking materials.			Assurance Nurse, Staff E	•	
				Coordinator, Unit Manage		
	An interview with Nur	se #2 revealed Residents		Worker and Activities stat		
	had a smoking evalua	ation done on admission and		concerns identified during	g the audit to	
		ing to assess if the Resident		include securing smoke p		
		pendent smoker, or if they		facility protocol, education		
		or safety. She further stated		and/or notification of the		
		where Resident #101 kept		Nursing (DON) or Admini		
	his smoking materials	5.		concerns. The Director of review the Smoking Para		
	In an interview with th	ne Director of Nursing (DON)		Tool weekly x 4 weeks th		
		AM, she indicated that staff		month to ensure all conce	•	
		Resident had smoking		addressed.		
	-	son or had not utilized the		The DON will present the	findings of the	
	lock box system. She	e stated she was unaware		Smoking Paraphernalia A		
		ept smoking materials on his		Quality Assurance Perfor		
		ng the lock box. The DON		Improvement (QAPI) com		
	indicated that staff ha	ad a duplicate key for each		for 2 months. The QAPI (	Committee will	

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If continuation sheet Page 18 of 31

					OMB NO. 09	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
					с	
		345113	B. WING		11/30/2	2023
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP	CODE	
		REHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE		
WILLOW	CREEN NURSING AND P	CERTABILITATION CENTER		GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE CC	(X5) DMPLETIO DATE
F 689	Continued From page	e 18	F 68	39		
	box in case a key wa			meet monthly for 2 month	is and review the	
				Smoking Audit Tool to det		
	An interview with the	Administrator on 11/30/23 at		and/or issues that may ne		
		at staff smoked outside in		interventions put into plac	e and to	
		Residents. She further		determine the need for fu	rther frequency	
		e to supervise the smoking		of monitoring.		
	area from inside the	cated there was no system in				
	0 ,	pendent smokers were				
		and she was unaware of any				
	-	the lock boxes for smoking				
	materials safe keepir	ng.				
	8/30/23 with diagnos	s admitted to the facility on es that included Diabetes bstructive Pulmonary ailure.				
	A review of Resident	#107's quarterly Minimum				
		d 1/7/23 revealed the				
	resident was cognitiv	ely intact with no behaviors.				
	It also indicated the F	Resident was a tobacco user.				
	A review of Resident	#107's care plan dated				
		Resident was an independent				
		igarettes. The goal was for				
		nue to smoke safely in				
		d would continue to use				
	-	afely through the next review.				
		d staff assistance obtaining om a secured storage area				
		ite resident's continued ability				
		consistent and regular				
		observe for potential				
	violations of the smol	king policy. It further stated				
		nt and report observations to				
		Administrative staff and to				
	provide education on	sate smoking to the				

Facility ID: 923020

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		345113	B. WING				C /30/2023	
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE			
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER			2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	and may smoke in de supervision. A review evaluations revealed monthly since admiss 2023. Resident #107 was of out to the smoking and 11/28/23 at 8:45 AM. materials from his from proceeded to light a co the lock box area. An observation of the at 8:25 AM revealed r boxes secured to the individually numbered In an interview with R 8:50 AM he revealed day. He stated in the boxes for Residents to materials in, and each kept by the Resident Resident stated he dii further stated staff knimaterials on his perso them to staff or use the In an interview with N 11/30/23 at 9:37 AM, Residents were prohi- materials on their person	king evaluation dated Resident was a safe smoker signated areas without of the Residents smoking they were performed tion to the facility in August beserved wheeling himself ea in his wheelchair on He then removed smoking nt shirt pocket and tigarette without first going to smoking area on 11/30/23 metal shelving with lock shelves. Each box was t. esident #107 on 11/28/23 at he smoked several times a interview there were lock to keep their smoking n box had a key that was it was assigned to. The d not use the lock box. He ew he kept smoking on as he had refused to give	F	689				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345113	B. WING				C 30/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER			2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 689	Continued From page	20	F	689			
	had a smoking evaluation then monthly by Nurs could remain an indep needed supervision for Resident #107 kept hiperson as he had refuin the past. Nurse #1 plastic toolbox that wat that had three packs on names on them. So to use this toolbox to materials before they system. Nurse #1 did cigarettes belonged. It toolbox was not kept to the system of the system of the system of the system of the system.						
	on 11/30/23 at 10:00 staff should have noti smoking materials on utilizing the lock box s there were cigarette p nurse's station. She fi unaware that Resider materials on his perso box. The DON indicat key for each box in ca An interview with the 1:00 PM indicated that the same area as the stated staff were able area from inside the k emergency. She indic place to check if inde using the lock boxes a	at #107 kept smoking on instead of using the lock and that staff had a duplicate ase a key was lost. Administrator on 11/30/23 at at staff smoked outside in Residents. She further to supervise the smoking					

Facility ID: 923020

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	-	D HUMAN SERVICES				FOR	D: 01/04/2024 M APPROVED
STATEMENT (	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	D. 0938-0391 E SURVEY PLETED
		345113	B. WING _				C /30/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 1	00,2020
					401 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER			GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	2/14/2023 with diagno absence of right leg b Heart Failure and Chr Disease. A review of Resident a Data Set (MDS) dated resident was cognitive It also indicated the R A review of the care p that Resident #119 was smoker of cigarettes. Resident to continue to designated areas and smoking materials sat Interventions included smoking materials fro upon request, evaluat to smoke safely on a basis, and for staff to	g. admitted to the facility on oses that included acquired elow the knee, Congestive onic Obstructive Pulmonary #119's quarterly Minimum d 10/27/23 revealed the ely intact with no behaviors. esident was a tobacco user. lan dated 10/26/23 revealed as an independent and safe The goal was for the to smoke safely in would continue to use fely through the next review. I staff assistance obtaining m a secured storage area te resident's continued ability consistent and regular observe for potential	F	589			
	staff were to documer	ing policy. It further stated ht and report observations to Administrative staff and to safe smoking to the					
	and may smoke in de supervision. A review evaluations revealed monthly since admiss 2023. In an interview with R	Resident was a safe smoker signated areas without of the Residents smoking					

Facility ID: 923020

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		345113	B. WING			C 11/30/2023		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER			2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	not have dialysis. He were lock boxes for R smoking materials in, that was kept by the F The Resident stated h as he only smokes a unaware if staff knew materials on his perso An observation of the 08:19 AM revealed R designated smoking a not yet started to smo a pack of cigarettes fr wheelchair. An observation of the at 08:25 AM revealed boxes secured to the numbered. An interview with Nur 11/30/23 at 9:30 AM s Residents were prohii materials on their per was unaware of wher smoking materials. An interview with Nur had a smoking evalua being allowed to smo evaluation was to ass an independent smok supervision for safety completed monthly. S unaware of where Re smoking materials.	stated in the interview there tesidents to keep their and each box had a key Resident it was assigned to. he does not use the lock box few times a week. He was he kept his smoking on. Resident on 11/30/23 at esident was outside in the area when I arrived. He had oke. Resident #119 removed rom the back of his smoking area on 11/30/23 metal shelving with lock shelves. Each box is sing Assistant (NA) #1 on stated she believed bited from keeping smoking son or in their rooms. She e Resident #119 kept his se #2 revealed Residents ation done by Nursing before ke at the facility. This sess if the Resident can be ter, or if they need . The evaluation was che further stated she was	F	689				

Facility ID: 923020

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345113	B. WING _			C 11/30/2023		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER			01 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 689 F 812 SS=E	staff should have noti smoking materials on utilizing the lock box s she was unaware tha smoking materials on the lock box. The DO duplicate key for each An interview with the 1:00 PM indicated that the same area as the stated staff were able area from inside the b emergency. She indic place to check if indep using the lock boxes a Residents not using the materials safe keepin Food Procurement, St CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pu gardens, subject to co safe growing and food (iii) This provision doe from consuming food	fied her if a Resident had their person or were not system. She further stated t Resident #119 kept his person instead of using N indicated that staff had a n box in case a key was lost. Administrator on 11/30/23 at it staff smoked outside in Residents. She further to supervise the smoking building in case of lated there was no system in bendent smokers were and she was unaware of any he lock boxes for smoking g. ore/Prepare/Serve-Sanitary 2) y requirements. e food from sources ed satisfactory by federal, es. bod items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility building and the second state state roduce with applicable	F				12/28/23	

Facility ID: 923020

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OLITICI		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		· · ·	TE SURVEY MPLETED
						С
		345113	B. WING		1	1/30/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	)E	
				2401 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND H	REHABILITATION CENTER		GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 812	Continued From page	o 24	F 81	2		
1 012			FOI	2		
		ance with professional				
	standards for food se	-				
		Γ is not met as evidenced				
	by: Based on observatio	on and staff interviews the		F 812		
	Based on observation and staff interviews, the facility failed to maintain clean dishes that were			1 012		
		led to dry small rectangular		On 11/29/23, the dietary man	ager under	
		g on the tray line ready for		the supervision of the dietary	•	
		hen observations. This		removed the 12 dinner plates		
		ential to affect food served to		tray line containing yellow an		
	all residents.			particles and removed the 57		
				rectangular bowls from the lu		
	Findings included:			that were stacked wet and co	•	
				yellow/black particles. The 12		
	During a follow up ob	servation tour of the kitchen		plates and 57 small, rectangu		
	on 11-29-23 at 11:42a			were re-cleaned and checked		
	Manager, the following concerns were observed. "There were 12 dinner plates on the tray line			dietary manager and dietary	•	
				ensure all were cleaned and		
	ready to be used for t			appropriately prior to being pl		
	contained yellow and			line for use.		
		ne had small rectangular				
	-	y to be used for the lunch		On 11/30/23, the administrate	or conducted	
		n revealed 57 of the bowls		a thorough inspection of the l		
	were stacked wet and	d contained yellow/black		include observation of plates	and small,	
	particles.			rectangular bowls stored for t	he tray line.	
				There were no issues identified	ed during the	
	The Dietary Manager			inspection.		
		. The Dietary Manager				
	confirmed the 12 dinner plates, and 57 small			On 11/29/23, an in-service wa		
	-	ere on the tray line ready to		the dietary consultant and die	•	
		meal. He explained the		manager for all dietary staff re		
	dishes went through			policy on Kitchen Cleaning Pi		
		ess. The Dietary Manager		include ensuring that all dish		
		per who ran the dishwasher		include but not limited to plate		
		son to check all dishware for		rectangular bowls are comple		
		re the dishes were dry prior		and dried prior to storing. The		
		e tray line. He said he was		will be completed by 12/28/23		
		check the dishware to		12/28/23, any dietary staff me		
	ensure the aisnes we	ere clean and dry once they		has not received the in-servic	e wiii de	

Facility ID: 923020

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STATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAAND PLAN OF CORRECTIONIDENTIFICATION NUMBER:		· · ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345113	B. WING	С	
		345113	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	11/30/2023
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
F 867	explained he had bee dishware today (11-2) kitchen staff had beer dishware could not be not know why staff wo rectangular bowls we Dietary Manager state ensure dishes were of them on the tray line During an interview w 11-29-23 at 2:37pm, f that the Dietary Mana Corporate Dietary Co The Administrator sta to be clean and dry p serving food.	The Dietary Manager en "too busy" to check the 9-23). He also explained the n in-serviced in the past that e stacked wet, and he did build have stacked the small t on the tray line. The ed he expected staff to clean and dry prior to placing for use. With the Administrator on the Administrator explained ager was new and that the insultant was training him. ted she would expect dishes rior to the dietary staff	F 81	<ul> <li>educated prior to the next schedu All newly hired dietary staff memb be in-service on Kitchen Cleaning Procedures during orientation by the Development Coordinator (SDC).</li> <li>The Director of Nursing and/or SE conduct kitchen rounds weekly x 4 then monthly x 1 month to ensure dishware to include but not limited dinner plates and small, rectangul are cleaned and dried completely being placed in the line for use. At concerns identified during the aud immediately addressed by the administrator to include providing additional training as appropriate. Administrator will review the Kitch tool weekly x 4 weeks, then month month to ensure completion.</li> <li>The administrator will present the of the Kitchen Audit Tool to the Qu Assurance Performance Improver (QAPI) committee monthly for 2 m The QAPI Committee will meet me for 2 months and review the Kitch tool to determine trends and/or iss may need further interventions pu place and to determine the need f further frequency of monitoring.</li> </ul>	ers will the Staff OC will 4 weeks, all 4 to lar bowls prior to ny lit will be The en Audit nly x 1 findings jality ment nonths. onthly en Audit sues that t into
F 867 SS=F	CFR(s): 483.75(c)(d) §483.75(c) Program f				12/28/23
		sh and implement written res for feedback, data			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/04/2024 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345113	B. WING			( 11/3	) 30/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER		2401 WAYNE MEMORIAL DRIV GOLDSBORO, NC 27534	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)		(X5) COMPLETION DATE
F 867	adverse event monito procedures must inclu- following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representativ information will be use are high risk, high vol opportunities for impre §483.75(c)(2) Facility systems to identify, co information from all de not limited to the facili §483.70(e) and include will be used to develop indicators. §483.75(c)(3) Facility and evaluation of perf including the methods development, monitor §483.75(c)(4) Facility including the methods systematically identify analyze and use data adverse events in the facility will use the data prevent adverse events \$483.75(d) Program s systemic action.	and monitoring, including ring. The policies and ude, at a minimum, the maintenance of effective d use of feedback and input other staff, residents, and res, including how such ed to identify problems that ume, or problem-prone, and ovement. maintenance of effective oblect, and use data and epartments, including but ity assessment required at ling how such information p and monitor performance development, monitoring, formance indicators, ology and frequency for such ring, and evaluation. adverse event monitoring, s by which the facility will v, report, track, investigate, and information relating to facility, including how the ta to develop activities to	F 867				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 01/04/2024 DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345113	B. WING			C 11/30/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COD		
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER		401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 867	implementing those a and track performance improvements are real §483.75(d)(2) The fact implement policies ad (i) How they will use a determine underlying impacting larger syste (ii) How they will deve will be designed to eff level to prevent qualit safety problems; and (iii) How the facility wi of its performance implementer that improvem §483.75(e) Program a §483.75(e)(1) The fact performance improve high-risk, high-volume consider the incidence of problems in those a outcomes, resident sa resident choice, and o §483.75(e)(2) Perform activities must track m resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activities	e improvement and, after ctions, measure its success, e to ensure that alized and sustained. clility will develop and ldressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or Ill monitor the effectiveness provement activities to nents are sustained. activities. clility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. nance improvement hedical errors and adverse vze their causes, and actions and mechanisms and learning throughout the	F 867			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/04/202 FORM APPROVED OMB NO. 0938-039
				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345113	B. WING		C 11/30/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WILLOW	CREEK NURSING AND F	REHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 867	conducted by the fact and complexity of the available resources, a assessment required Improvement projects annually a project that problem-prone areas collection and analys (c) and (d) of this sect §483.75(g) Quality as §483.75(g)(2) The quassurance committee governing body, or de functioning as a gove activities, including in program required und (e) of this section. The (ii) Develop and imple action to correct iden (iii) Regularly review data collected under resulting from drug re available data to mak This REQUIREMENT by: Based on record rev facility's Quality Asse (QAA) committee fail- procedures and moni- committee had previce for one repeat deficie Medicaid/Medicare C (F582) originally cited recertification and co	cy of improvement projects ility must reflect the scope e facility's services and as reflected in the facility at §483.70(e). s must include at least at focuses on high risk or identified through the data is described in paragraphs stion. seessment and assurance. Hality assessment and e reports to the facility's esignated person(s) erning body regarding its nplementation of the QAPI der paragraphs (a) through the committee must: ement appropriate plans of tified quality deficiencies; and analyze data, including the QAPI program and data egimen reviews, and act on the improvements. T is not met as evidenced iew and staff interviews, the essment and Assurance ed to maintain implemented itor interventions that the pusly put into place. This was ency in the area of coverage Liability Notice	F 86	7 F 867 QAPI/QAA Improvement Ac On 12/20/2023, the Clinical Consu initiated an audit of all previous cita from 7/29/2021 to 11/27/2023 relat 582 Medicaid/Medicare Coverage/ Notice to ensure the Quality Assur (QA) committee has maintained ar monitored interventions that were place. Action plans were revised a updated and presented to the QA	Itant ations ted to F Liability ance nd put into

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			()(0)	E CONSTRUCTION	OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
					С
		345113			11/30/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WILLOW	CREEK NURSING AND F	REHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO
F 867	Continued From page	e 29	F 867	7	
	recertification and con The continued failure federal surveys of rec facility's inability to su Assessment and Ass Findings included: This tag is cross refe F582: Based on reco interviews, the facility Skilled Nursing Facili Notice of non-covera- the estimated out of p 3 residents reviewed (Residents #70, #134) During the recertifica- investigation survey of to provide an acknow Facility Advanced Be and a Notice of Medio discharge from Medio	mplaint investigation survey. of the facility during two cord shows a pattern of the ustain an effective Quality urance Program. renced to: rd review and staff failed to provide a complete ty Advanced Beneficiary ge (SNF ABN) by omitting pocket cost for care for 3 of for beneficiary notices I, #393).		Committee by the Director of Nursin (DON) for any concerns identified. Clinical Consultant will address all concerns identified during the audit include but not limited to the educat staff. This audit will be completed b 12/28/2023. On 12/8/2023, the Clinical Consulta conducted an in-service with the Administrator, Director of Nursing (I and Quality Assurance (QA) Nurse regarding the Quality Assurance (Q process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed prevent the reoccurrence of deficien practice to include pharmacy service infection control. In-service also inc identifying issues that warrant development and establishing a sys monitor the corrections and implem changes when the expected outcom not achieved and sustaining an effer QA process. All newly hired administrators, DONs, and QA nurs be educated during orientation regat the QA Process. All data collected for identified area concerns related to F 582 Medicaid/Medicare Coverage/Liabil Notice will be taken to the Quality Assurance committee for review mo x 3 months by the Director of Nursin (DON). The Quality Assurance com will review the data and determine i plans of correction are being follows	The to to to fill of the to to to to to to to the to to the to th

Event ID: XIQS11

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		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/04/2024 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345113	B. WING				C /30/2023
NAME OF P	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
				240	01 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND F	REHABILITATION CENTER		GC	OLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	Continued From page			867	education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting the QA Nurse and/or the DON. The Clinical Consultant will ensure the facility is maintaining an effect QA program by reviewing the Quality Assurance and Performance Improvement (QAPI) quarterly meetin minutes and ensuring implemented procedures and monitoring practices address interventions related to F 582 Medicaid/Medicare Coverage/Liability Notice and all current citations and QA plans are followed and maintained quarterly x2. The Clinical Consultant of immediately retrain the Administrator, DON, and QA nurse for any identified areas of concern. The results of the monthly Quality Assurance meeting minutes will be presented by the Administrator to the Quality Assurance and Performance Improvement (QAPI) Committee Qua x 2 for review and the identification of trends, development of action plans are indicated to determine the need and/or frequency of continued monitoring.	by g g A vill	

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