SEP 1 7 2013

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345113	B. WNG	····	·····	09	/12/2013		
NAME OF PROVIDER OR SUPPLIER WILLOW CREEK NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  2401 WAYNE MEMORIAL DRIVE  GOLDSBORO, NC 27534					
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 371 SS=E	considered satisfacto authorities; and	ERVE - SANITARY sources approved or ry by Federal, State or local stribute and serve food	F	371	The tea in the canister and watermelon in the walk in refrige were immediately discarded by Dietary Manager upon discover these items being uncovered by surveyor; both items were re-prepfor the Residents.	rator the y of the	09/20/2013		
	by: Based on observation facility failed to cover the presence of flies. Beginning at 9:02 AM	is not met as evidenced n and staff interview the food and beverage items in Findings include: on 09/11/13, during food on, flies were observed in		THE PROPERTY OF THE PROPERTY O	All other food items which is susceptible to contamination is checked to ensure they were projectored to prevent back contamination; any other obseitems uncovered were discarded re-prepared for the Residents.	were perly terial rved	09/20/2013		
	canisters, full of brewers At 10:25 AM on 09/11 stated the staff usually canisters with plastic	0:23 AM on 09/11/13 two tea ed tea, were left uncovered. /13 a dietary employee y covered the tops of the wrap or aluminum foil to from contaminating the			All Dietary staff will be re-educate the Dietary Manager or designed the importance and standard covering all food items that susceptible to bacterial contamination bugs and insects.	on for are	09/20/2013		
ABORATORY I	filling a pitcher with te canister to pour into e ice. She stated this to residents at the lunch observed in the kitche	ight-ounce cups filled with ea would be served to meal. Flies were still	lE <sub>1</sub>		TITLE		(X6) DATE		
	THON	was a second sec	//	ÚŚ	trater		9/16/13		

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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345113	B. WNG			09/	12/2013
	SUMMARY ST. (EACH DEFICIENC	REHABILITATION CENTER  ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	24 G	TREET ADDRESS, CITY, STATE, ZIP CODE  401 WAYNE MEMORIAL DRIVE  OLDSBORO, NC 27534  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 371	Continued From page At 11:18 AM on 09/11 walk-in refrigeration v There were eight row which fresh watermel watermelon had beer dietary employee con had plastic covers wh the salads, desserts, contaminated. Flies v kitchen at this time.  At 11:06 AM on 09/12 (DM) reported that du staff were trained to c kitchen and storage a	e 1 //13 a cart pushed into the vas observed uncovered. s of trays on the cart on on cubes or pureed in placed. At this time a namented the staff usually nich fit over the carts to keep or fruit from being were still observed in the		371		e will for days; gative ected / the ill be then nsure	09/20/2013

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				DECEIVEPRINTED: 11/04/2013 FORM APPROVED 0M8 NO. 0938-0391						
,	STATEMENT	Y OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LY DIN	YIPLE CONSTRUCTION NOV I 8 2013 (XS) DATE SURVEY COMPLETED					
		. 345113			B. WING CONSTRUCTION SECTION 10/30/2013						
_	NAME OF	PROVIDER OR SUPPLIER	···		Ļ	STREET ADDRESS, CITY, STATE, ZIP CODE  2401 WAYNE MEMORIAL DRIVE	_				
	WILLOW	CREEK NURSING A	ND REHABILITATION CENTER		L	GOLDSBORO, NC 27534					
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN O'E.CORRECTION (AS) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE DEFICIENCY)  PROVIDER'S PLAN O'E.CORRECTION (AS) COMPLETION DATE					
	K 000	INITIAL COMMENT		K	00	send the required audible indicator to 11/30/2013 the fire panel has been repaired and					
		This Life Safety Coc conducted as per TI at 42 CFR 483.70(a Health Care section publications. This bu construction, one ste automatic sprinkler	te(LSC) survey was he Code of Federal Register ); using the 2000 Existing of the LSC and its referenced uilding Is Type V (211) ory, with a complete system. termined during the survey			All other PIV valve tamper alarms will be tested to ensure that they are functioning properly and have the required audible and visual indicators	•				
K 056 SS=E	are as follows:		ΚO	)5(	at the required panel.						
		for the installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5				The maintenance director or designee will test all PIV valve tamper alarms weekly 4 weeks and then monthly times 3 months to ensure that the required audible and visual functions are working properly and sending the appropriate signal to the required panel.					
		Surveyor: 27871 Based on observatio approximately 12:00 items were noncomp include: both PIV val	not met as evidenced by:  ns and staff interview at am onward, the following bliant, specific findings ues located at back of facility le signal to fire alarm control	<b>;</b>		The Quality Assurance committee will review the weekly and monthly audits weekly times 4 weeks and then monthly times 3 months to ensure continued compliance and will adjust this plan as necessary if any negative limitings are found during the audit period.					
V	BORATORY	DIRECTOR'S OR PROVIDE	RISUPPLIER REPRESENTATIVE'S SIGN	ATURE		AO TILE (X6) DATE					
_		X/ VC				Tohin strator 11-18-13					
fo da	her selegyer	ide blovide sulficient piole late of survey whether or r the date these document	ection to the pallents (See Instructions	.)_Exécpi r nursing	ta. he	ullon may be excused from connecting providing it is determined that.  bir.nursing homes, the findings stated above are discloseble 60 days————————————————————————————————————					
FC	)RM CMS-256	37(02-99) Pravious Versians O	bsolete Event ID: OCIM21		F	facility ID: 923020 If continuation sheet Page 1 of 2					

9917-359 95:51, £105/81/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 11/04/2013 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID S		1			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SU IDENTIFICATION	PPLIERICUA (X2) MU	LTIPLE CONSTRUCTIO DING 01 - MAIN BUILD		(X3) DATE SURVEY COMPLETED	
345	113 B. WING			10/30/2013	
NAME OF PROVIDER OR SUPPLIER		1	CITY, STATE, ZIP CODE		
WILLOW CREEK NURSING AND REHABILITA	TION CENTER	2401 WAYNE MEI GOLDSBORO, I	, ,		
(X4) ID SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDE TAG REGULATORY OR LSC (DENTIFYING INF	ED BY FULL ! PREF	EACH CO	SER'S PLAN OF CORRECTION RRECTIVE AUTION SHOULD ERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
K 056 Continued From page 1 panel when tested.	K	ስረል!	fied fire/smoke dam cleaned to alfow pro	[,44,00,004,004,00	
42 CFR 483.70(a) K 067 NFPA 101 LIFE SAFETY CODE ST	· FANDARD K	067		. ,	
Heating, ventilating, and air condition with the provisions of section 9.2 and in accordance with the manufacture specifications. 19.5.2.1, 9.2, NFP 19.5.2.2	d are installed c's	1	e/smoke damper supp ked and cleaned if need ain proper operat	ded 11/30/2013	
This STANDARD is not met as evic Surveyor: 27871 Based on observations and staff int approximately 12:00 am onward, the items were noncompliant, specific finclude: fire/smoke dampers throug are maintained in operating condition 42 CFR 483.70(a)	erview at e following ndings h out facility .	will audit fit weekly tim monthly the they are control of the quality meet weekly monthly tire continued of this plan as findings are	nance Director or designee/smoke damper supples 4 weeks and the nes 3 months to ensolvent and maintained and the same and the same and the same and will addition.	vill hen 11/30/2013	
FORM CMS-2587(02-99) Previous Versions Obsolete	Event ID: 0ClM21	period.	if continue	ation sheet Page 2 of 2	e de la constitución de la const

## PRINTED: 11/04/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 ~ BUILDING:02 B. WING 10/30/2013 345113 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2401 WAYNE MEMORIAL DRIVE WILLOW CREEK NURSING AND REHABILITATION CENTER GOLDSBORO, NC 27534 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL JD PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 K 000 | INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V (211) construction, one story, with a complete automatic sprinkler system. No Life Safety Code deficiencles determined during the survey.

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excusad 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

FORM CMS-2567(02-99) Previous Versions Obsolete

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

Event ID: 0CIM21

Facility ID: 923020

If continuation sheet Page 1 of 1

20

(XB) DATE

program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PE NOTE OF CORRECTION (X1) PE NOTE OF CORRECTION (X2)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 03 - BUILDING		1 .	(X3) DA'	(XS) DATE SURVEY COMPLETED	
		345113	B, WING	<u> </u>	<u> </u>		30/2013	
	Provider or Supplier CREEK NURSING A	ND REHABILITATION CENTER	2	401 Wayne me Soldsboro,	1 ,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL. BO IDENTIFYING INFORMATION)	ID PREFIX TAG	EACH C	DER'S PLAN OF CORRE ORRECTIVE ACTION SH FERENCEO TO THE API DEFICIENCY)	OULD BE	(XS) COMPLETION DATE	
K 000	INITIAL COMMENT	rs .	K 000					
-	conducted as per T at 42 CFR 483.70(a Health Care section publications. This b	de(LSC) survey was he Code of Federal Register i); using the 2000 Existing of the LSC and its referenced uilding is Type V (211) ory, with a complete		:				
	•	deficiencies determined		·				
	·							
480RATORY	DIRECTORS OR PROVIDI	ensupplier representative's sign	ATURE	Alix	mie istrator		(X6) DATE (8-13	
her safegua:	rds provide sufficient prot late of survey whether or the dale these documen	n asterisk (*) denotes a deficiency which solves to the patients. (See instructions not a plan of correction is provided. For are made available to the facility. If	s.) Except for or nursing hom	n may be excus nursing homes, les, the above fir	ed from correcting proving he findings stated above the findings stated above the first of contract the first	iding it is deter re are discloss rection are disc	mined that ble 90 days locable 14	

FORM CMS-2587(02-99) Previous Versions Obsoleto

Event ID; 0CIM21

Facility 10: 923020

If continuation sheet Page 1 of 1

6 W