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

PRINTED: 03/11/2016 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 02/10/2016	
	345113	B. WING				
NAME OF PROVIDER OR SUPPLIER WILLOW CREEK NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
No deficiencies were	cited as a result of the	FO				
						(X6) DATE
	ROVIDER OR SUPPLIER CREEK NURSING AND F SUMMARY ST. (EACH DEFICIENC REGULATORY OR I INITIAL COMMENTS No deficiencies were complaint investigation Event ID# GSSN11.	ROVIDER OR SUPPLIER CREEK NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted on 02/10/16. Event ID# GSSN11.	ROVIDER OR SUPPLIER CREEK NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS F 0 No deficiencies were cited as a result of the complaint investigation conducted on 02/10/16.	ROUTER OR SUPPLIER CREEK NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies were cited as a result of the compilaint investigation conducted on 02/10/16. Event ID# GSSN11.	ROWIDER OR SUPPLIER CREEK NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY WIS PRECIDENCES (EACH DEPICIENCY WIS PRECIDENCES (EACH ORDER OF THE APPROPRIATION) INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted on 02/10/16. Event ID# GSSN11.	A BUILDING ON THE CATION NUMBER 345113 B. WING CREEK NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPOCENCY MUST BE PRECEDED BY FULL REDULATORY OR LISC DENTIFYING INFORMATION) INITIAL COMMENTS No deficiencies were cited as a result of the compliant investigation conducted on 02/10/16. Event ID# GSSN11.

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.

Electronically Signed

Facility ID: 923020

03/03/2016