STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING _____ B. WING _____	C 08/26/2016

NAME OF PROVIDER 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiences were cited as a result of the complaint investigation. Event ID #J2HV11.	F 000		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		9/9/16

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

Electronically Signed | 09/06/2016

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F 441	Continued From page 1 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to promptly separate a resident on isolation precautions for Clostridium Difficile (Resident #8) from a resident with a wound (Resident #341) for 1 of 1 residents observed for isolation precautions. Findings included: Review of the facility Infection Control Manual (Policy) Version date 9/2014 (Page Revision: 08/24/15) revealed under Clostridium Difficle Infection: Consideration for Resident Placement, listed as a bullet point "Placing resident in room with resident that does not have open wounds, tubes, immunosuppression or terminal illness and diseases." Review of the Physician's Orders dated 08/18/16 revealed Resident #8 was to receive Vancomycin 125 milligrams (mg) by mouth twice each day for 10 days and was placed on Contact Precautions for C-Diff (Clostridium Difficile). Review of the Physician's Orders dated 06/07/16 revealed Resident #341 received dressing changes to a right lateral heel pressure ulcer every other day. In an observation and interview on 08/25/16 at 9:52 AM a Contact Isolation sign was seen posted on the door of the room shared by Resident #8 and Resident #134. When asked about the reason for isolation Nursing Assistant (NA) #1 stated Resident #8 was on isolation for C-Diff. In an observation and interview on 08/25/16 at	F 441	Willow Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Willow Creek Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Willow Creek Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F441 Resident #341 was moved to another room without isolation precautions on 8/25/16 by nursing. 100% audit was completed of all current residents to include residents #8 and #341 to ensure that residents on isolation	

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F 441	Continued From page 2 5:35 PM Resident #341 had been moved to another room in the facility. When Resident #341 was asked the reason for the move, Resident #341 did not know the reason. In an interview on 08/25/16 at 5:45 PM, the Assistant Director of Nursing (ADON) stated Resident #341 was moved because the roommate (Resident #8) had C-Diff. In an interview on 08/25/16 at 6:08 PM, the Social Worker (SW) stated she had been told that Resident #341 needed a room change to occur to prevent cross contamination. She indicated the facility was usually able to catch residents with wounds and feeding tubes pretty quickly and separate them from residents with infections. In an interview on 08/25/16 at 6:20 PM, the Director of Nursing (DON) stated if a resident was on isolation for C-diff the roommate should not have a wound or any type of invasive device such as a gastric feeding tube, intravenous line, or a catheter. She indicated that the floor nurses and the treatment nurse should have been aware that Resident #8 had been diagnosed with C-diff and that Resident #341 had a wound. The DON stated it was her expectation that if a resident had any type of infection requiring isolation that they not be in a room with a resident with a wound or an invasive device. She stated it was her expectation that Resident #341 would have been moved when Resident #8 was diagnosed with C-diff. In an interview on 08/25/16 at 7:07 PM, Nurse #1 stated she was the nurse that received the order and placed Resident #8 on isolation precautions on 08/18/16. She indicated she did not know Resident #341 had a wound but that she should have checked to make sure. Nurse #1 stated the purpose of moving one of the residents was to prevent cross contamination.	F 441	precautions were not sharing a room with a resident who has a wound, tube, immunosuppressant or terminal illness, and disease completed on 8/25/16 by the QI LPN, QI RN, RN Supervisor, ADON, and the Resource nurse using a resident census. No other residents identified on isolation precaution were found sharing a room. 100% inservice was initiated with all licensed nurses regarding consideration for resident placement/room sharing of residents on isolation precautions to include clostridium difficle by the facility consultant and the facility staff facilitator on 8/25/16 with a completion date of 9/9/16. When a resident is placed on isolation precautions to include for clostridium difficle, the hall nurses will initiate the isolation precautions to include placing appropriate sign on door, ensuring required personal protective equipment is accessible, and ensuring residents with open wounds, tubes, immunosuppression or terminal illness and disease are not cohorted in the room with the resident on isolation precaution. The QI LPN, QI RN, RN Supervisor, ADON, and the Resource nurse will review all new physician orders, MD visit consult sheets and newly admitted residents discharge summaries to identify residents that require isolation precautions, to ensure proper procedures were followed to include, ensuring residents with open wounds, tubes, immunosuppression or terminal illness and disease are not cohorted in the room with the resident on isolation precaution,	

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F 441	Continued From page 3 In an interview on 08/26/16 at 8:50 AM, the Treatment Nurse stated she did not know Resident #8 was on isolation prior to being asked about it that morning. She indicated she never noticed an isolation sign hanging on the door or the Personal Protective Equipment (PPE) hanging over the door. In an interview on 08/26/16 at 9:50 AM, NA who was usually assigned to Resident #8 and Resident #341 stated the isolation sign and PPE were placed last week when resident #8 returned from an outside appointment.	F 441	using an Isolation Precaution QI tool 3 x per week x 4 weeks, weekly x 4 weeks, then monthly x 1 month. The QI LPN, QI RN, RN Supervisor, ADON, and the Resource nurse will ensure residents are immediately separated and provide retraining with the license nurse for any identified areas of concern noted during the audit. The DON will review and initial the Isolation Precaution QI tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the Isolation Precaution QI tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency and monitoring monthly x 3 months.	