

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

PRINTED: 08/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/06/2018
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	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 583 SS=D	<p>Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)</p> <p>§483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>§483.10(h)(I) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff, the facility failed to protect the private health</p>	F 583	F583 Personal Privacy/Confidentiality of	7/21/18	

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

TITLE

(X6) DATE

Electronically Signed

07/19/2018

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.

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F 583	Continued From page 1 information 2 of 3 sampled residents (Resident #'s 8 and 9) by leaving confidential medical information unattended and exposed in an area accessible to the public. Findings included: 1a. A continuous observation was made on 7/5/18 from 10:20 AM through 10:32 AM of an unattended medication cart (500 Hall Medication Cart). The medication was observed unattended from 10:20 AM until Nurse #1 approached the cart at 10:32 AM. A yellow sticker was attached to the metal bar atop the cart. Visible on the yellow sticker was a resident's name (Resident #8), and a type of medication (stool softener) used by Resident #8. When Nurse #1 approached the medication cart she stated she was the nurse responsible for the 500 Hall medication cart. She also stated she typically placed the yellow stickers on a blank order sheet and placed them inside the Medication Administration Record book so they were not exposed. She stated the yellow sticker for Resident #8's stool softener was exposed, but should have been protected since it contained health information considered private. She stated she was in-serviced on patient privacy at hire and annually. b. A continuous observation was made on 7/5/18 from 10:35 AM through 10:40 AM of an unattended treatment cart outside Room 206. There was a Treatment Administration Record exposed on top of the cart which contained the resident's name (Resident #9), and other protected health information, such as "Clean abscesses to bilateral armpits /c (with) WC (wound cleanser). Apply TAO (triple antibiotic ointment)." An interview was conducted with Wound Care Nurse #1 at 10:40 AM on 7/5/18. She stated, "That sheet was turned over when I left this cart. I don't know who left it exposed."	F 583	Records CFR(s): 483.10(h)(1)-(3)(i)(ii) The process that lead to the deficiency was based on observations and interviews with staff, the facility failed to protect the private health information 2 of 3 sampled residents (Residents #'s 8 and 9) by leaving confidential medical information unattended and exposed in an area accessible to the public. 100% audit will be completed by 7/20/2018 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Quality Improvement (QI) nurse, Resource nurses, LPN Resident Liaison, Minimum Data Set (MDS) nurse, and/or the Facility Consultants of the residents private health information including any fax/electronic transmittal from outside physicians' offices and pharmacy that contains the message " The information contained in the facsimile message is confidential intended only for the use of the individual or entity named as recipient" to ensure the private information is not unattended and exposed in an area accessible to the public. 100% observations will be conducted by 7/20/2018 the Director of Nursing (DON), Assistant Director of Nursing (ADON), QI nurse, Resource nurses, LPN Resident Liaison, MDS nurse, and/or the Facility Consultants with all staff to include license nurses to ensure that residents private health information, to include resident medication labels, are not left on med cart, treatment cart, counter top and other accessible areas in all nurse stations.		

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F 583	Continued From page 2 She also stated it should not have been left exposed since it contained protected health information. An interview was conducted with the facility Administrator, on 7/5/18 at 11:20 AM. He stated his expectation was for protecting confidential health information with every measure possible. He also stated stickers should not be exposed to public view, and TARs (Treatment Administration Records) should not be left exposed on top of the treatment cart. He also stated both should be treated like all other sensitive resident information.	F 583	100% in-service was initiated by the Staff Facilitator with all staff to include administrator, Director of Nursing, Assistant Director of Nursing, Quality Improvement nurses, RN supervisor, CNAs, dietary staff, license nurses, agency nurses, housekeeping department, maintenance department, central supply, receptionist, agency staff, department managers (social workers, therapy, medical records, activities, bookkeeping, payroll) regarding the data privacy and security provisions for safeguarding personal medical and health information, Confidential resident information would be covered and protected at all times. 10% of all staff in each department to include CNAs, dietary department, license nurses, housekeeping department, maintenance department, central supply, receptionist, agency staff, and department managers will be observed by the ADON, QI nurse, Resource nurses, treatment nurses, LPN Resident liaison, and/or MDS nurse, weekly x 8 weeks then monthly x 1 month to ensure that any resident's private health information is not left unattended or exposed in public accessible area, to include resident medication labels, utilizing a Resident Medical Information Audit Tool. Any concerns will be immediately addressed by the ADON, QI nurse, Resource nurses, treatment nurses, LPN Resident Liaison, and/or MDS with reeducation of staff during the time of the audit. The DON will review and initial the Resident Medical Information Audit Tools weekly x 8 weeks		

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F 583	Continued From page 3	F 583	<p>then monthly x 1 month for completion and to ensure all areas of concern were addressed.</p> <p>The Executive QI committee will meet monthly and review the Resident Medical Information Audit Tools and address any issues, concerns, and/or trends as well as make changes as needed to include continued frequency of monitoring monthly x 3.</p> <p>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.</p>		