DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í				E SURVEY PLETED
		345113	B. WING _			07	/14/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		2	401 WAYNE MEMORIAL DRIVE		
	SREEK NORSING AND R			G	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156 SS=C	RIGHTS, RULES, SE The facility must infor and in writing in a lan understands of his or regulations governing responsibilities during facility must also prov notice (if any) of the S §1919(e)(6) of the Ac made prior to or upon resident's stay. Rece any amendments to it writing. The facility must infor entitled to Medicaid b of admission to the nu- resident becomes elig- items and services th facility services under which the resident ma- other items and service and for which the resi- the items and service (i)(A) and (B) of this s The facility must infor at the time of admissi the resident's stay, of facility and of charges including any charges under Medicare or by	m the resident both orally guage that the resident her rights and all rules and president conduct and g the stay in the facility. The vide the resident with the State developed under t. Such notification must be a dmission and during the sipt of such information, and t, must be acknowledged in m each resident who is enefits, in writing, at the time ursing facility or, when the gible for Medicaid of the at are included in nursing the State plan and for ay not be charged; those ces that the facility offers ident may be charged, and s for those services; and when changes are made to s specified in paragraphs (5) section. m each resident before, or on, and periodically during services available in the	F	156			7/14/16
	legal rights which incl A description of the m	udes: nanner of protecting personal					
LADUKAIUKY	DIRECTORS OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

**Electronically Signed** 

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.

08/04/2016

PRINTED: 08/10/2016

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/10/2016 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		E SURVEY PLETED
		345113	B. WING			07/	/14/2016
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW	CREEK NURSING AND R	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	funds, under paragram A description of the re- for establishing eligibit the right to request ar 1924(c) which determ non-exempt resource institutionalization and spouse an equitable sc cannot be considered toward the cost of the medical care in his or down to Medicaid eligin A posting of names, a numbers of all pertine groups such as the Si agency, the State lice ombudsman program advocacy network, ar unit; and a statement complaint with the Sta agency concerning re- misappropriation of re- facility, and non-comp directives requirement The facility must infor name, specialty, and physician responsible The facility must prom- written information, ar applicants for admissi- information about how Medicare and Medica	ph (c) of this section; equirements and procedures ility for Medicaid, including in assessment under section nines the extent of a couple's as at the time of d attributes to the community share of resources which available for payment e institutionalized spouse's ther process of spending gibility levels. addresses, and telephone ent State client advocacy tate survey and certification ensure office, the State in the protection and not the Medicaid fraud control that the resident may file a ate survey and certification esident abuse, neglect, and esident property in the obliance with the advance nts. m each resident of the way of contacting the e for his or her care.	F	156			

If continuation sheet Page 2 of 14

					OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345113	B. WING		07/14/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO	
F 156	Continued From page	2	F 156	5		
	by: Based on observation facility failed to post a for the State Agency of the facility. Findings included: On 7/11/16 at 12:48 F the facility and resided entry, it was observed information located or between the men's re and lifts storage close information for the Me Complaint Intake Unit Service Regulation was for the names and con numbers listed were of message that the num disconnected or were At 1:35 PM on 7/11/16 information board, loc the facility, was made information posted the incorrect. Random observations remainder of the survi was updated while su and it was not. On 7/14/16 at 11:44 A that she would be the the posting information	called and all returned a nbers had been no longer in services. 6, observation of the other cated at the front entrance of and revealed that the State ere was also outdated and s were made throughout the ey to see if the information rveyors were in the building		<ul> <li>Willow Creek Nursing and Rehabilit Center acknowledges receipt of the Statement of Deficiencies and prop this plan of correction to the extent findings is factually correct and in o maintain compliance with applicable and provisions of quali-ty of care of residents. The plan of correction is submit-ted as a written allegation of compliance.</li> <li>Willow Creek Nursing and Rehabilit Center's response to this Statemen Deficiencies does not denote agree with the Statement of Deficiencies r does it constitute an admission that deficiency is accurate. Further,</li> <li>Willow Creek Nursing And Rehabilit Center reserves the right to refute a the deficiencies on this Statement of Deficiencies through Informal Dispu- Resolution, formal appeal procedur and/or any other administrative or le pro-ceeding.</li> </ul>	e oses of rder to e rules f ration t of ment nor any tation any of of te e	

Facility ID: 923020

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	DF DEFICIENCIES	MEDICAID SERVICES	(Y2) MUUT	IPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	NG	COMPLETED
		345113	B. WING _		07/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE
WILLOW	CREEK NURSING AND I	REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE
F 156	facility and reported to was responsible for the her arrival, but she wone. She reported the knowledge, the inform correct and that she accuracy every 6 mo She was not aware to	that she did not know who keeping it updated prior to yould be the one from now at, to the best of her mation that was posted was had planned to check it for onths to keep it up to date. hat the names and contact a Agency were incorrect and	F1	<ul> <li>The postings were chan correct numbers require department of social ser Complaint intake unit, O program, Medicare (Soci Office) and Medicaid Offiby calling the numbers of Regional Vice President The postings were re-hut the Administrator with the numbers.</li> <li>All areas in the facility wistate agency in-formation by Regional Vice Presid on 7/14/16 to ensure conto include contact inform The Regional Vice Presid Operations corrected an information found to be if the audit.</li> <li>The Administrator and D were re-educated on 7/1 nurse consultant and Represident of Operations postings for the state agency utilization.</li> <li>The Administrator or Dimwill review state agency in all areas of the X 3 months to ensure conto include contact inform utilizing a State Agency</li> </ul>	d for the local vices, NC imbudsman cial Security fices and verified on 7/14/16 by the c of Operations. ung on 7/14/16 by re correct with postings of on were checked ent of Operations rrect information nation was posted. ident of id re-posted and inaccurate dur-ing Director of Nursing 14/16 by the RN egional Vice on the required iency for resident ector of Nursing information e facility monthly porrect information nation is posted

Facility ID: 923020

If continuation sheet Page 4 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/10/20 FORM APPROVE OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345113	B. WING		07/14/2016
NAME OF P	ROVIDER OR SUPPLIER	L	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER		401 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 156	Continued From page	9 4	F 156	found to be inaccurate during audit.	
				The Executive QI committee will mee monthly and review the state agency posting QI audit tool and address any issues, concerns, and/or trends and n changes as needed, to include contin frequency of monitoring monthly X 3 months.	nake
F 241 SS=D	manner and in an env	note care for residents in a vironment that maintains or ent's dignity and respect in	F 241		8/11/16
	by: Based upon observa staff and resident inte compromised the digu assess for and mainta one resident reviewed services, Resident #2 The facility's Minimum assessment dated 06 #213 was cognitively behaviors such as rej The same assessmen Resident #213 had a vascular accident (str extensive assistance was frequently incont annual assessment o Resident #213 was no	hity of a resident by failing to ain a toileting plan for one of d for urinary incontinence 213. Findings included: n Data Set (MDS) annual 206/2016 indicated Resident intact and displayed no ection of care or wandering.		F241 Resident #213 was assessed on 7/14 by Registered Nurse Minimum Data S Coordinator for potential for Bowel/Bladder re-training and was pla on a scheduled toileting program on 7/14/16 by Registered Nurse Minimur Data Set Coordinator. On 7/14/16 res #213 care plan and Resident Care Gu (RCG) were updated for the addition of the scheduled toileting program and resident preference in wearing adult depends by Registered Nurse Minimu Data Set Coordinator. 100% of alert and oriented residents, include resident #213, that are incontinent, will be interviewed using	Set aced n ident uide of

Facility ID: 923020

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED	
		345113	B. WING		07/14/2016	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW	CREEK NURSING AND R	REHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STENET OF DELIVITOR DELIVITOR	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE	
F 241	Continued From page	e 5	F 24	1		
	customary routine.			questions: Are you aware when	/ou need	
		#213's nursing care plan		to go to the bathroom?; Is it your		
		I4 and last revised on		preference to wear a brief?; Wou		
	06/10/2016 revealed	there was a measurable		like to try a toileting program?, us	sing the	
		s in place to address urinary		"Initiation of Toileting Program In		
		to her impaired mobility.		tool", interviews to be conducted	-	
		ons to address her urinary		Quality Indicator RN and LPN, R	N	
		praise and encourage all		Supervisor, RN Staff Facilitator,		
	attempts to comply w	rith tolleting. Resident #213 on 07/12/2016		RN-ADON by 8/10/16. Those de		
		ed she did not feel she was		to meet the criteria will be placed scheduled toileting program. Car		
		and dignity by the nursing		and RCG will be updated to refle		
	staff members, and the			toileting program by		
		ry toileting as needed.		Registered Nurse Minimum Data	Set	
	Resident #213 stated			Coordinator and completed by 8/		
	assistants told her sh	e did not have time for				
	helping her with her in	ncontinent care, and that the		100% of Nursing staff, RN, LPN,	and	
	nursing assistant's sta	atement made her feel		C.N.A.'s, will be in-serviced on th		
	embarrassed and ash			scheduled toileting program to in		
		with Resident #213at 9:20		documentation in the POC and id		
		he was observed sitting up in		residents on scheduled toileting		
		sleeve top and an adult		Resident Care Guide by RN Staf		
	disposable brief. During an observation	n of the resident on		Facilitator. "Scheduled Toileting I (Toilet before meals, after meals)	•	
	-	AM, Resident #213 was		and as needed)", and Treat reside		
		bed wearing a long sleeve		Dignity and Respect in-services		
	shirt and an adult dis	<b>v</b>		initiated August 2, 2016 by RN-A		
		A) #1 stated in an interview		All nursing new hires will receive		
	· · ·	O PM that she provided		in-services re-garding scheduled		
		er assigned residents every		program to include documentation		
		stated that none of her		and identifying residents on sche		
		ncluding Resident #213, was		toileting per the resident care gu	-	
	on a toileting plan.			staff facilitator. "Scheduled Toilet	-	
	In an interview with N			Pro-gram: Toilet before meals, at moole, gHS, and are provided", a		
		ed that the minimum data set		meals, qHS, and ass needed", a Residents with Dignity and Resp		
	regulation) informatio	essment required by federal		during orientation.	501,	
		d by nurses. She stated				
					1	

Facility ID: 923020

If continuation sheet Page 6 of 14

CENTER		MEDICAID SERVICES			OMB NO. 0	PPROVE 938-039
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
		345113	B. WING		07/14/	/2016
	ROVIDER OR SUPPLIER CREEK NURSING AND R	REHABILITATION CENTER	24	TREET ADDRESS, CITY, STATE, ZIP CODE 401 WAYNE MEMORIAL DRIVE OLDSBORO, 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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 241	whether he/she wanter program and whether cognition to follow at t In an interview with M at 2:35 PM, she state not placed on a toiletin an option for her. ME residents on a toiletin toileted before meals throughout the shift. care plan meeting wa according to a social know whether toiletin meeting, as the social and there were no mi meeting. In an interview with R nurse, Nurse #1 on 0 stated she thought Re a toileting program, b been stopped. She e cognitively capable of and that she was fund the bedside commod In an interview with R nurse, Nurse #2 on 0 stated she felt the res handling a toileting pr cognitively intact. Nur referred her for a toile Resident #213 stated 07/14/2016 at 9:40 A plan months ago and was stopped. Reside her feel embarrassed one to assist her to the	e resident to determine ed to be on a toileting the resident had sufficient oileting program. IDS Nurse #2 on 07/13/2016 dd that Resident #213 was ing program, but that it was DS Nurse #2 stated that all g program should be , after meals, and as needed MDS #2 also stated that a is planned for 06/21/2016 services note, but did not g had been discussed at the l worker was not available, nutes from the care plan tesident #213's day shift 7/13/2016 at 3:31 PM, she esident #213 used to be on ut was not sure why it had explained Resident #213 was f following a toileting plan ctionally able to transfer to e or walk to the bathroom. tesident #213's evening 7/13/2016 at 3:33 PM, she sident was capable of rogram, as she was rse #2 stated she had not eting plan.	F 241	the Registered Nurse Minimum Coordinator will review all currer in-house residents including re- for changes and updates to current status for toileting progru updates to care plan and care of made by Registered Nurse Min Set Coordinator utilizing the R4 assessment. Documentation of residents on toileting, to include resident #27 reviewed daily during clinical m the DON, ADON, RN Superviso Nurse and/or QI nurses for resi progression in toileting program through Friday X 4 weeks then weeks then monthly X 3 month time those residents will be re- to include resident #213, for co on scheduled toileting program, re-evaluation for Toileting Progr Care plans and RCG will be up reflect the continued toileting pri Registered Nurse Minimum Da Coordinator, and completed on updates and changed to the re- toileting program. Documentator residents that continue on sche toileting program, to include resi #213, if applicable, will be revise during clinical meeting by DON, ADON supervisor, MDS nurse and/or of for resident's progression in toi program weekly X 4 weeks, the X 3 months.	ent sident #213 ram, with guides imum Data AI/MDS scheduled 13, will be neeting by or, MDS ident's n Monday weekly X 4 s. At that evaluated, ntinuation ntinuation using the ram Tool. dated to rogram by ta Set going for sident's ion of eduled sident eved daily N, RN QI nurses leting	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923020

PRINTED: 08/10/2016 FORM APPROVED

				CONSTRUCTION	OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345113	B. WING		07/14/2016
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
	CREEK NURSING AND R	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIC
F 241	Continued From page	e 7	F 241		
	staff often did not res			The Executive QI committee will meet	
		he Assistant Director of		monthly and review audits and addres	s
		at 1:29, PM, she stated that		any issues, concerns, and/or trends a	
	-	a resident for a toileting		to make changes as needed, to includ	le
		The ADON stated the nurse		continued frequency of monitoring	
	make the referral.	the administrative nurse to		monthly X 3 months.	
		1DS Nurse #1 on 07/14/2016			
		d she could not establish			
		an had been initiated for			
	Resident #213 in the	past and that she would			
	initiate one.				
F 315		ETER, PREVENT UTI,	F 315		8/11/16
SS=D	RESTORE BLADDEF	۲ ۲			
	Based on the residen	t's comprehensive			
		ity must ensure that a			
	resident who enters t	he facility without an			
		not catheterized unless the			
		dition demonstrates that			
		ecessary; and a resident			
		bladder receives appropriate es to prevent urinary tract			
		ore as much normal bladder			
	function as possible.				
	This REQUIREMENT	is not met as evidenced			
	by:				
	Based upon observa	tions, record review, and		F315	
		erviews, the facility failed to		Resident #213 was assessed on 7/14/	-
		or participation in toileting		by Registered Nurse Minimum Data S	et
		mpled resident, Resident # nary incontinence care.		Coordinator for potential for Bowel/Bladder re-training and was pla	red
	Findings included:			on a scheduled toileting program on	
				7/14/16 by Registered Nurse Minimum	n
	The annual Minimum	Data Set (MDS)		Data Set Coordinator. On 7/14/16 resi	
	assessment dated 06	06/2016 indicated Resident		#213 care plan and Resident Care Gu	

Facility ID: 923020

If continuation sheet Page 8 of 14

		MEDICAID SERVICES	a			NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		ATE SURVEY OMPLETED
		345113	B. WING			07/14/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
	CREEK NURSING AND F	REHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
		ATEMENT OF DEFICIENCIES				0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 315	Continued From page	e 8	F 31	5		
		intact and displayed no		(RCG) were up-dated for	r the addition of	
		jection of care or wandering.		the scheduled toileting p		
	The same assessme			resident preference in w	•	
		diagnosis of cerebral		depends by Registered I		
		roke), that she required		Data Set Coordinator.		
	extensive assistance	with toileting, and that she				
		tinent of the bladder. The		100% of alert and oriente	,	
		of 06/06/2016 also indicated		include resident #213, th		
		ot on a scheduled toileting		incontinent, will be inter	-	
		d strong preferences for her		questions: Are you awar	-	
	customary routine.	#213's nursing care plan		to go to the bathroom?; I preference to wear a brid		
		14 and last revised on		like to try a toileting prog	-	
		there was a measurable		"Initiation of Toileting Prog		
		is in place to address her		tool". Interviews were co	-	
	-	related to her impaired		Quality Indicator RN and	-	
	mobility. The stated	goal was to keep the		Supervisor, RN Staff Fac	cilita-tor,	
		urinary tract infection. One of		RN-ADON by 8/10/16. T		
	the interventions to a			to meet the criteria will b		
	-	praise and encourage all		scheduled toileting pro-g		
		vith toileting. Other goals		and RCG will be updated	d to reflect the	
		luded on the nursing care		toileting program by	um Data Cat	
	plan addressed Resignation assistance with the p			Registered Nurse Minim Coordinator and complete		
		unction with her activities of			leu by 0/11/10.	
	daily living, including			100% of Nursing staff, R	N I PN and	
		so in place regarding her		C.N.A.'s, will be in-service		
		vn and her risk for falls.		scheduled toileting progr		
	In an interview with F	Resident #213 on 07/12/2016		documentation in the PC		
		ed she did not did not receive		residents on scheduled t		
		ing as needed. Resident		Resident Care Guide by		
		w when she had to urinate,		Facilitator. "Scheduled T		
	-	nt told her she did not have		(Toilet before meals, after	-	
		vith her toileting needs.		and as needed)", Treat r		
		A) #1 stated in an interview		Dignity and Respect in-s		
		0 PM that she provided er assigned residents every		initiated August 2, 2016 All nursing new hires will		
		stated that none of her		in-services re-garding sc		
		ncluding Resident #213, was		program to include docu		

Facility ID: 923020

If continuation sheet Page 9 of 14

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		IO. 0938-03
		IDENTIFICATION NUMBER:		G	. ,	IPLETED
		345113	B. WING		0	7/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		1/14/2010
				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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
			-			
F 315	Continued From page	e 9	F 31	15		
	on a toileting plan.			and identifying residents	on scheduled	
	In an interview with M	linimum Data Set (MDS)		toileting per the resident	care guide by	
	Nurse #1 on 07/13/20	016 at 2:30 PM, she stated		staff facilitator. "Schedul	ed Toileting	
	that the minimum dat	a set assessment (an		Program: Toilet before m	eals, after meals,	
	assessment required	by federal regulation)		qHS, and ass needed", a	and Treat	
	information was base	d upon assessments		Residents with Dignity a	nd Respect,	
	provided by nurses.	She stated that criteria for		during orientation.		
	initiating a toileting pl	an included an assessment				
	of the resident to dete	ermine whether he/she		During the Quarterly MD	S assessment,	
	wanted to be on a toi	leting program and whether		the Registered Nurse Mi	nimum Data Set	
	the resident had suffi	cient cognition to follow a		Coordinator will review a	Il current	
	toileting program.			in-house residents includ	ling resident #213	
	In an interview with M	IDS Nurse #2 on 07/13/2016		for changes and updates	sto	
	at 2:35 PM, she state	d that Resident #213 was		current status for toileting	g program, with	
	not placed on a toileti	ing program but it was an		updates to care plan and	l care guides	
	option for her. MDS	Nurse #2 stated that all		made by Registered Nur	se Minimum Data	
	residents on a toiletin	g program should be		Set Coordinator utilizing	the RAI/MDS	
	toileted before meals	, after meals, and as needed MDS #2 also stated that a		assessment.		
	care plan meeting wa	is planned for 06/21/2016		Documentation of reside	nts on scheduled	
		services note, but did not		toileting, to include resid	ent #213, will be	
	-	g had been discussed at the		reviewed daily during cli		
		l worker was not available,		the DON, ADON, RN Su		
		nutes from the care plan		Nurse and/or QI nurses		
	meeting.			progression in toileting p	rogram Monday	
	In an interview with R	esident #213's day shift		through Friday X 4 week		
	nurse, Nurse #1 on 0	7/13/2016 at 3:31 PM, she		weeks then monthly X 3	months. At that	
	stated she thought Re	esident #213 used to be on		time those residents will	be re-evaluated,	
	a toileting program, b	ut was not sure why it had		to include resi-dent #213	, for continuation	
	been stopped. She e	explained Resident #213 was		on scheduled toileting or	discontinuation	
	cognitively capable o	f following a toileting plan,		of scheduled toileting pro	ogram, using the	
	that she was function	ally able to transfer to the		re-evaluation for Toileting	g Program Tool.	
	bedside commode or	walk to the bathroom, and		Care plans and RCG wil	be updated to	
		t by scheduled toileting.		reflect the continued toile		
	In an interview with R	esident #213's evening		Registered Nurse Minim		
	nurse, Nurse #2 on 0	7/13/2016 at 3:33 PM, she		Coordinator, and comple		
	stated she felt the res	sident was capable of		updates and changed to	the resident's	
		ogram and that she was		toileting program. Docu	mentation of	
	cognitively intact. Nu			residents that continue of		1

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	S FOR MEDICARE &			CONSTRUCTION	OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345113	B. WING		07/14/2016
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
WILLOW	CREEK NURSING AND F	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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 315	Continued From page	e 10	F 315		
F 520 SS=D	referred her for a tolk Resident #213 stated 07/14/2016 at 9:40 A plan months ago and was stopped. Reside her feel embarrassed one to assist her to th stated she used the of to the bathroom or th staff often did not res In an interview with th Nursing on 07/14/16 any nurse could refer program screening. who were cognitively for a toileting program contact one of the ad the referral. In an interview with N at 1:45 PM, she state whether a toileting pla Resident #213 in the initiating an one for h On 07/14/2016 at 2:1 provided a copy of a Services for Resident was dated 07/14/201 following: "Please ev bowel/bladder retrain toileting program." 483.75(o)(1) QAA COMMITTEE-MEMB QUARTERLY/PLANS	eting plan. I in an interview on M that she was on a toileting that she had no idea why it ent #213 also stated it made to wear a diaper and for no ne bathroom. Resident #213 call bell to call for assistance e bedside commode, but pond. ne Assistant Director of at 1:29, PM, she stated that r a resident for a toileting The ADON stated residents intact were good candidates n and that any nurse could ministrative nurses to make MDS Nurse #1 on 07/14/2016 ed she could not establish an had been initiated for past and that she would be er. 0 PM, MDS Nurse #2 Screen/Referral to Rehab t #213. The referral sheet 6 and documented the valuate resident for ing to implement scheduled ERS/MEET	F 520	toileting program, to include resider #213, if applicable, will be reviewed during clinical meeting by DON, ADON, F supervisor, MDS nurse and/or QI r for resident's progression in toiletin program weekly X 4 weeks, then n X 3 months. The Executive QI committee will m monthly and review audits and add any issues, concerns, and/or trend to make changes as needed, to ind continued frequency of monitoring monthly X 3 months.	d daily N nurses ng nonthly eet tress s and

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/10/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345113	B. WING		07/14/2016
	ROVIDER OR SUPPLIER Creek Nursing and F	REHABILITATION CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIC
F 520	facility; and at least 3 facility; and at least 3 facility's staff. The quality assessme committee meets at I issues with respect to and assurance activit develops and implem action to correct iden A State or the Secre disclosure of the reco except insofar as suc compliance of such of requirements of this s Good faith attempts I and correct quality de a basis for sanctions. This REQUIREMENT by: Based upon staff inte the facility's Quality A failed to prevent the n practice for urinary in resulted in a repeat of showed a pattern of t sustain an effective O included: This citation is cross-	<ul> <li>a other members of the</li> <li>ent and assurance</li> <li>east quarterly to identify</li> <li>b which quality assessment</li> <li>ties are necessary; and</li> <li>nents appropriate plans of</li> <li>tified quality deficiencies.</li> <li>tary may not require</li> <li>brods of such committee</li> <li>ch disclosure is related to the</li> <li>committee with the</li> <li>section.</li> <li>by the committee to identify</li> <li>eficiencies will not be used as</li> <li>T is not met as evidenced</li> <li>erview and record review,</li> <li>Assurance (QA) committee</li> <li>reoccurrence of deficient</li> <li>continence care which</li> <li>citation at F 315 in its annual</li> <li>of 07/14/2016. The citing of</li> <li>eral surveys of record</li> <li>the facility's inability to</li> <li>QA program. Findings</li> </ul>	F 520	F520 The Administrator, DON, and QI Nur will be educated by the Corporate N Consultant on 8/10/16 on the QI pro to include implementation of Action I Monitoring Tools, the Evaluation of t process, and modification and corre if needed to prevent the reoccurrence deficient practice to include for urina incontinence care. The Administrator, DON, and QI Nur	urse icess, Plans, he Ql ction ce of ary
	observations, record resident interviews, the resident for participat	review, and staff and he facility failed to assess a tion in toileting program for 1 t, Resident # 213, reviewed		will be educated by the Corporate consultant on 8/10/16 on the QA pro to include identifying issues that wan development and establish a system	ocess

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	S FOR MEDICARE &		0/00 10		OMB NO. 0938-0
IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345113		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		B. WING		07/14/2016	
NAME OF PROVIDER OR SUPPLIER WILLOW CREEK NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			2		
			GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		HOULD BE COMPLE
F 520	Continued From page	e 12	F 520		
	for urinary incontinence care.			monitor the corrections and imp changes when the expected out	
	Review of the facility's survey history revealed F 315 was cited during the 08/07/2016 annual recertification survey of 08/07/2015, and was			not achieved and sustaining an QA program.	
	re-cited during the 07/14/2016 annual recertification survey.			The RN Assistant Director of Nu completed 100% audit of previo and action plans within the past	us citation year to
	During an interview with the Administrator on 07/14/2016 at 3:19 PM, she stated that the QA committee met on a quarterly basis to focus on			include urinary incontinence to e the QI committee has maintaine monitored interventions that we	ed and re put in
	solutions for identified areas of concern. She explained the facility's department managers (QA members) provided reports at each meeting based upon their audit tools, and if problems			place. Action plans will be revise updated and will be presented to Committee by the RN Assistant Nursing on 8/11/16 for any conc	o the QI Director of
	were not being resolved, then a performance improvement plan was initiated. She added that			identified.	
	she was new to the facility and that she had initiated a new tool for identifying quality of care issues by establishing "guardian angel" rounds for all residents in the facility.			All data collected for identified a concerns to including urinary ind will be taken to the Quality Assu Committee for review monthly X	continence irance
	The Corporate Vice President stated in an interview at 3:25 PM on 07/14/2016 he			by the Quality improvement Nur Quality Assurance Committee w the data and determine if plans	se. The vill review
	understood that QA c successful if there wa	ommittee had not been as a repeat deficiency for care. He stated that the		correction are being followed, if in plans of action are required to outcomes, if further staff educat	changes o improve
	facility corporation ha management for the f Administrator and Dir	d recently hired new facility, including a new ector of Nursing, in order to		needed, and if increased monitor required. Minutes of Quality Ass Committee will be documented	oring is surance monthly at
	-	lity and bring about positive ality of care concerns.		each meeting by the RN QI nurs	
				facility is maintaining and effecti program by reviewing and initial Executive Quarterly meeting mi ensuring implemented procedur monitoring practices to address	ve QA ling the nutes and

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		345113			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		07/14/2016
		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 COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
PREFIX (EACH DEFICIENC)		LSC IDENTIFYING INFORMATION)	F 52		citations and paintained ponsultant will trator, dentified Quality will be tor and/or nittee I identification ction plans as eed and/or

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