STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING ____________________________
   PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345113

B. WING _____________________________

DATE SURVEY COMPLETED
   C 03/23/2017

WILLLOW CREEK NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
   2401 WAYNE MEMORIAL DRIVE
   GOLDSBORO, NC  27534

STATEMENT OF DEFICIENCIES
   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 000 INITIAL COMMENTS
   No deficiencies were cited as a result of the complaint investigation of 3/23/17. Event ID # NE4i11.

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

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.