DEPARTMENT OF HEALTH	AND HUMAN SERVICES					M APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		ONSTRUCTION		SURVEY PLETED
	345113	B. WING			06/	/01/2018
NAME OF PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW CREEK NURSING AN			240	1 WAYNE MEMORIAL DRIVE		
WILLOW CREEK NORSING AN			GO	LDSBORO, NC 27534		
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 550 SS=D Resident Rights/E CFR(s): 483.10(a) §483.10(a) Reside The resident has a self-determination access to persons outside the facility this section. §483.10(a)(1) A fa with respect and or resident in a many promotes mainter her quality of life, individuality. The fill promote the rights §483.10(a)(2) The access to quality of severity of condition must establish any practices regarding provision of service residents regardle §483.10(b) Exercion The resident has a rights as a resider or resident of the §483.10(b)(1) The resident can exercise	xercise of Rights ((1)(2)(b)(1)(2) ent Rights. a right to a dignified existence, , and communication with and a and services inside and , including those specified in actility must treat each resident lignity and care for each her and in an environment that ance or enhancement of his or recognizing each resident's facility must protect and of the resident. e facility must provide equal care regardless of diagnosis, on, or payment source. A facility d maintain identical policies and g transfer, discharge, and the les under the State plan for all ss of payment source. se of Rights. the right to exercise his or her at of the facility and as a citizen	F 5	50	DEFICIENCY)		6/29/18
free of interference reprisal from the for rights and to be su	e resident has the right to be e, coercion, discrimination, and acility in exercising his or her upported by the facility in the ER/SUPPLIER REPRESENTATIVE'S SIGNATUR			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.

06/22/2018

PRINTED: 07/10/2018

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		O. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	i	CON	IPLETED
		345113	B. WING		0	6/01/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	CREEK NURSING AND F	REHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	COMPLETIC
F 550	Continued From page	e 1	F 55	0		
	exercise of his or her	rights as required under this				
	subpart.	5				
	This REQUIREMENT	is not met as evidenced				
	by:					
	Based on record rev			Resident Rights/Exercise of Ri	-	
		erviews, the facility failed to		CFR(s): 483.10(a)(1)(2)(b)(1)(2)	
		nified manner by dressing a		The presses that lead to the de	ficiones	
		gown instead of her clothes ings of embarrassment for 1		The process that lead to the de was based on record review, of		
		ed for dignity (Resident		and resident and staff interview		
	#101).			facility failed to provide care in		
				manner by dressing a resident		
	Findings included:			hospital gown instead of her clo		
	Ū			resulted in feelings of embarras		
		ed Resident #101 was		1 of 4 residents reviewed for di	gnity	
		y on 4/3/2018 with diagnoses		(Resident #101).		
		ardial Infarction (heart				
	attack) and Hyperten			100% interviews were complete		
		1DS) dated 4/10/2018		alert and oriented residents, to		
		t was cognitively intact and		resident #101, on 6.25.18 by th		
		total assistance of 1 staff		Workers (SW). The SW asked		
		ies of daily living. The MDS		resident the preference regardi		
	resident to choose wi	as very important to the		clothing choices. The Minimur nurses (MDS) updated the resid		
				guides on 6.26.18 to reflect the		
	An observation was r	nade of Resident #101 on		resident s daily clothing choice	es. All	
	5/29/2018 at 2:30 PM			non-alert and oriented residents		
		in bed. The resident was		representative were asked the		
	sleeping and was dre	essed in a hospital gown.		preference regarding the reside	•	
				clothing choices. 100% audit w		
		ducted with Resident #101		completed on 6.26.18 by the Di		
		6 AM. The resident stated		Nursing (DON), the Assistant D		
		e closet in the room. The		Nursing, the RN supervisor, the	•	
		e staff dressed her in a		Improvement (QI) nurses, and		
	-	f the time. The resident		Facilitator for all alert and orien		
		it was easier for the staff to al gown instead of dressing		residents to ensure each reside treated with dignity and respect	-	
		sident stated she told the		given a choice of clothing for th		
	staff several times that			all non- alert and oriented resid	-	

Facility ID: 923020

If continuation sheet Page 2 of 26

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
		345113	B. WING			C/04/2049
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		6/01/2018
				2401 WAYNE MEMORIAL DRIVE	-	
WILLOW	REEK NURSING AND	REHABILITATION CENTER		GOLDSBORO, NC 27534		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO DATE
F 550	Continued From page	ae 2	F 55	0		
		es rather than a hospital	1 00	being treated with dignity and	respect by	
		e clothes in the closet. The		following the resident preferen		
	0	ne felt embarrassed at times		regarding the resident s daily		
	to be dressed in a h	ospital gown when she had		choices, on the resident care	•	
	visitors.			identified issues were address		
	An observation and			immediately by the DON on 6.		
		interview was conducted with 31/2018 at 2:09 PM. The		ensure each resident is being dignity and respect by being g		
		had a bath earlier and		choice of clothing for the day.	iven a	
		IA) #5 dressed her in a		100% in-service of licensed nu	urses, to	
		resident stated NA #5 did not		include agency nurses, and nu	ursing	
	ask if she wanted to	wear clothes.		assistants, to include Nursing		
	.			(NA) #5, was initiated by the S		
		nducted with Nursing		Facilitator on 6.18.18 regardin	-	
		n 5/31/2018 at 2:29 PM. NA as the NA assigned to		residents right to choose their the day, and to make choices		
		worked with her almost every		aspects of his or her life in the		
		PM shift. NA # 5 reported		are significant to the resident i	-	
		nt a bath earlier in the shift		their bathing preferences. The	in-service	
		a hospital gown. NA #5		will be completed by 6.26.18.		
	-	ask the resident about		staff will be in serviced by the		
	-	did not know why. NA #5 sier to put a hospital gown on		Facilitator during orientation re resident s right to choose the	• •	
	-	indicated she was aware the		for the day, and to make choic		
		in the closet but never		aspects of his or her life in the		
	dressed her in clothe	es unless the resident was		are significant to the resident i	-	
	going out for an app	ointment.		their bathing preference.		
	An inter i			10% of all residents, to include		
		nducted with the Director of /31/208 at 3:35 PM. The DON		#101, will be reviewed by the Director of Nursing, the Qualit		
	• • •	on was for residents to be		Improvement (QI) nurses, the	•	
		uring the day to maintain their		supervisor, and Staff Facilitate		
	dignity.			residents are being treated with		
	-			and respect by being given a c	choice of	
				clothing 3 times week for 4 we		
				weekly for 4 weeks then mont	•	
				month using a Clothing Audit		
1				Director of Nursing will review	and initial	

Event ID: 7LOS11

Facility ID: 923020

If continuation sheet Page 3 of 26

PRINTED: 07/10/2018 FORM APPROVED

	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /		COMPLETED	
		345113	B. WING		06	/01/2018
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW	CREEK NURSING AND R	REHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE		
meeon				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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 550 F 561 SS=D	CFR(s): 483.10(f)(1)- §483.10(f) Self-detern The resident has the promote and facilitate through support of re- not limited to the righ (1) through (11) of thi §483.10(f)(1) The res activities, schedules (waking times), health care services consist assessments, and pla applicable provisions §483.10(f)(2) The res choices about aspect facility that are signifi §483.10(f)(3) The res with members of the	(3)(8) mination. right to and the facility must e resident self-determination sident choice, including but ts specified in paragraphs (f) s section. ident has a right to choose (including sleeping and care and providers of health ent with his or her interests, an of care and other of this part. ident has a right to make s of his or her life in the	F 550	 weeks then monthly for 1 month for completion and to ensure all identifie areas of concern were addressed. The Executive QI committee will mereview the Resident Care Audit tool monthly for 3 months to determine is and trend to include continued monit frequency. The Administrator and the DON will I responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring re- to the plan of correction. 	et to ssues coring be f	6/29/18

If continuation sheet Page 4 of 26

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 07/10/2018 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
		345113	B. WING		06	6/01/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
				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 OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 561	Continued From page	e 4	F 56	51		
	§483.10(f)(8) The ress participate in other activity religious, and commu- interfere with the righ facility. This REQUIREMENT by: Based on record reverses assed on record reverses resident and staff inter honor resident's choice a hospital gown inster to provide a resident for 2 of 5 residents ref (Resident #101and R Findings included: 1-Record review reverses admitted to the facility which included Myoca attack) and Hypertens Minimum Data Set (Mi indicated the resident required extensive to member for all activity further indicated it was resident to choose with An observation was re 5/29/2018 at 2:30 PM observed in her room	bident has a right to ctivities, including social, inity activities that do not ts of other residents in the T is not met as evidenced iew, observation and erviews, the facility failed to ce by dressing a resident in ad of her clothes and failed with showers as scheduled eviewed for choices tesident # 21). ealed Resident #101 was y on 4/3/2018 with diagnoses ardial Infarction (heart sion. The Admission MDS) dated 4/10/2018 t was cognitively intact and total assistance of 1 staff ies of daily living. The MDS as very important to the hat clothes to wear. made of Resident #101 on		 F561 Self-Determination CFR(s): 483.10(f)(1)-(3)(8) The process that lead to the dawas based on record review, of and resident and staff interview facility failed to honor residents dressing a resident in a hospital instead of her own clothes and provide a resident with shower scheduled for 2 of 5 residents #101 and Resident #21). 100% interviews were complete alert and oriented residents, to resident the preference regard clothing choices. The Minimum nurses (MDS) updated the resiguides on 6.26.18 to reflect the resident and oriented resident r	bbservation ws, the s choice by al gown d failed to rs as (Resident ted with all o include the Social the ling daily im Data Set ident care e ses. All ts	
	An interview was con on 5/30/2018 at 10:46	ducted with Resident #101 6 AM. The resident stated		preference regarding the resid clothing choices. 100% intervi completed with all alert and or	ent⊡s daily iews were iented	
	resident indicated the	e closet in the room. The e staff dressed her in a		residents, to include resident # 6.25.18 by the Social Workers	(SW)	
	hospital gown most o	f the time. The resident		regarding preferences for bath	ing. The	

Facility ID: 923020

If continuation sheet Page 5 of 26

PRINTED: 07/10/2018

		MEDICAID SERVICES				OMB NO		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY	
		345113	B. WING			06/	01/2018	
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE			
WILLOW	CREEK NURSING AND F	REHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I		(X5) COMPLETIO	
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		DATE	
F 561	Continued From page	e 5	F 56	51				
		it was easier for the staff to			Minimum Data Set nurses (MDS) upd	ated		
		al gown instead of dressing			the resident care plans and the reside			
		sident stated she told the			care guides on 6.27.18 to reflect the			
		ere were clothes in the			residents bathing preferences. All			
		ndicated she preferred to			non-alert and oriented residents will b	е		
		of a gown but the staff only			given a shower per policy as medically			
		s when she went out for an			indicated.	,		
	appointment.				100% audit was completed on 6.27.18	3 bv		
					the Director of Nursing (DON), the			
	An observation and ir	nterview was conducted with			Assistant Director of Nursing, the Qua	lity		
	Resident #101 on 5/3	31/2018 at 2:09 PM. The			Improvement (QI) nurses, the RN	5		
	resident stated she h	ad a bath earlier and			supervisor, and Staff Facilitator for all			
		A) #5 dressed her in a			residents to ensure each resident is b	eina		
		esident stated NA #5 did not			treated with dignity and respect by	- 0		
	ask if she wanted to				following the resident preference			
					regarding the resident s daily clothing	2		
	An interview was con	ducted with Nursing			choices and to ensure each resident is			
		5/31/2018 at 2:29 PM. NA			given the choice of a shower or bath p			
	#5 confirmed she was				their preference, on the resident care			
		orked with her almost every			guides. All identified issues were			
	day on the 7AM to 3	PM shift. NA # 5 reported			addressed immediately by the DON o	n		
	-	t a bath earlier in the shift			6.27.18 to ensure each resident is give			
	-	hospital gown. NA #5			the choice of a shower or bath per the			
		ask the resident about			preference. All identified issues were			
	-	did not know why. NA #5			addressed immediately by the DON o	n		
	-	ier to put a hospital gown on			6.27.18 to ensure each resident is bei			
		ndicated she was aware the			treated with dignity and respect by bei	0		
	resident had clothes i	in the closet but never			given a choice of clothing for the day a	and		
	dressed her in clothe	s unless the resident was			to ensure each resident is given the			
	going out for an appo	intment.			choice of a shower or bath per their			
					preference, on the resident care guide			
	An interview was con	ducted with the Director of			100% in-service of licensed nurses, to)		
	Nursing (DON) on 5/3	31/208 at 3:35 PM. The DON			include agency nurses, and nursing			
	-	n was for residents' choices			assistants, to include Nurse #4, Nursin	-		
	to be honored and for	r residents to be dressed in			assistants (NA) #5 and #6, was initiate	ed		
	clothes during the day	y if that was their			by the Staff Facilitator on 6.1.18 regar	-		
	preference.				the resident right to choose their cloth			
					for the day, and to make choices about			
	2 Pocord roviow rove	aled Resident #21 was			aspects of his or her life in the facility	that	I	

Facility ID: 923020

If continuation sheet Page 6 of 26

					OMB NO. 0938-03		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345113	B. WING		06/01/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WILLOW	CREEK NURSING AND F	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)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL P		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETIO
F 561	Continued From page	e 6	F 56	1			
	admitted to the facility diagnoses which inclu- and Hypertension. Re- Minimum Data Set (M- indicated the resident required extensive as for bathing. The MDS important for the reside bath and a shower. T resident displayed nor An interview was con 5/29/2018 at 10:16 A required assistance w further stated she pre- could not remember to one. The resident sta- if she wanted a show Review of the shower nurses' station reveal scheduled for shower on Wednesdays and An interview was con 5/31/2018 at 9:39 AW did not receive a show (Wednesday 5/30/20 shower. An interview was con 5/31/2018 at 10:17 A was the nurse respor Nurse #4 reported sh	y on 8/27/2017 with uded Urinary Tract Infection eview of the Quarterly /IDS) dated 2/22/2018 t was cognitively intact and asistance of 1 staff member 6 further indicated it was very dent to choose between a file MDS revealed the orejection of care. ducted with Resident #21 on M. The resident stated she with bathing. The resident efferred to take a shower but the last time she was given ted the staff did not ask her er. r schedule posted at the led Resident #21 was rs on the 7AM to 3PM shift Saturdays. ducted with Resident #21 on 1. The resident stated she wer the day before 18) and was not offered a ducted with Nurse #4 on M. Nurse #4 confirmed she nsible for Resident #21. e was the nurse responsible		are significant to the resident includit their bathing preferences. The in-set will be completed by 6.26.18. All net staff will be in serviced by the Staff Facilitator during orientation regardit resident □s right to choose their cloth for the day, and to make choices ab aspects of his or her life in the facilit are significant to the resident includit their bathing preference. 10% of all residents, to include resident #101and resident #21, will be review the Assistant Director of Nursing, the Quality Improvement (QI) nurses, the supervisor, and Staff Facilitator to e residents are being treated with digr and respect by being given a choice clothing and that each resident is giv the choice of a shower or bath per the preference, on the resident care gui times week for 4 weeks, then weekl weeks then monthly for 1 month usi Resident Care Audit Tool. The Direc Nursing will review and initial the Ref Care Audit Tool weekly for 8 weeks monthly for 1 month for completion a ensure all identified areas of concer were addressed. The Executive QI committee will me review the Resident Care Audit tool monthly for 3 months to determine is and trend to include continued monit frequency The Administrator and the DON will	rvice w ng the hes yout ty that ing dent wed by e he RN ensure hity of ven heir des 3 y for 4 ng a ctor of esident then and to n eet to ssues itoring be		
	5/31/2018 at 10:17 A was the nurse respon Nurse #4 reported sh for the resident on W The nurse stated the shower the day befor Nurse #4 confirmed W	M. Nurse #4 confirmed she nsible for Resident #21. e was the nurse responsible ednesday, May 30, 2018.		monthly for 3 months to determine is and trend to include continued moni frequency	itoring be of %		

Facility ID: 923020

If continuation sheet Page 7 of 26

	OF DEFICIENCIES	MEDICAID SERVICES		CONSTRUCTION	(X3) DATE S	. 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		345113	B. WING		06/01/2018	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VILLOW	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 561	Continued From page	e 7	F 561			
	Nurse #4 indicated th					
		vers and she did not know				
		ted there was adequate staff id not complete the showers.				
	An interview was cor	ducted with Nursing				
		n 5/31/2018 at 10:23 AM. NA				
	#6 confirmed she wa					
	-	/ before and worked with the				
		A #6 indicated she did not ent's scheduled shower day				
		e schedule. NA #6 stated she				
		ent a shower the day before				
	and had not given the	e resident a shower in a long				
		ne did not know why she had				
	not given the residen	t a shower.				
	An interview was cor	nducted with the				
	Administrator on 10/3	31/2018 at 10:30 AM. The				
		the expectation was showers				
		only on the scheduled				
F 582	shower days but daily	y. Coverage/Liability Notice	F 582			6/29/18
SS=B	CFR(s): 483.10(g)(17	U	F 302			0/29/10
	§483.10(g)(17) The f	acility must				
		aid-eligible resident, in				
	-	admission to the nursing				
	Medicaid of-	resident becomes eligible for				
		rvices that are included in				
		es under the State plan and t may not be charged;				
		s and services that the				
		which the resident may be				
	charged, and the am	ount of charges for those				
	services; and					
		caid-eligible resident when				

Facility ID: 923020

If continuation sheet Page 8 of 26

F DEFICIENCIES			PLE CONSTRUCTION	1/231 0 47	E SURVEY
CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	G	· · ·	IPLETED
	345113	B. WING		06/01/2018	
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
REEK NURSING AND R	EHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETIO DATE
Continued From page	8	F 58	32		
changes are made to specified in §483.10(g	the items and services				
resident before, or at periodically during the available in the facility services, including an covered under Medica facility's per diem rate (i) Where changes in and services covered Medicaid State plan, t notice to residents of reasonably possible. (ii) Where changes ar items and services that	the time of admission, and e resident's stay, of services y and of charges for those y charges for services not are/ Medicaid or by the e. coverage are made to items by Medicare and/or by the the facility must provide the change as soon as is re made to charges for other at the facility offers, the				
60 days prior to imple (iii) If a resident dies of transferred and does	mentation of the change. or is hospitalized or is not return to the facility, the				
representative, or esta deposit or charges alr per diem rate, for the resided or reserved o	ate, as applicable, any ready paid, less the facility's days the resident actually r retained a bed in the				
discharge notice requ (iv) The facility must r resident representativ	irements. efund to the resident or re any and all refunds due				
date of discharge from (v) The terms of an ac behalf of an individual facility must not confli	n the facility. dmission contract by or on I seeking admission to the				
	SUMMARY ST (EACH DEFICIENC) REGULATORY OR L Continued From page changes are made to specified in §483.10(g section. §483.10(g)(18) The far resident before, or at periodically during the available in the facility services, including an covered under Medica facility's per diem rate (i) Where changes in and services covered Medicaid State plan, fan otice to residents of reasonably possible. (ii) Where changes an items and services that facility must inform that 60 days prior to imple (iii) If a resident dies of transferred and does facility must refund to representative, or est deposit or charges all per diem rate, for the resided or reserved o facility, regardless of discharge notice requi (iv) The facility must r resident representative the resident within 30 date of discharge from (v) The terms of an ac behalf of an individua facility must not conflit these regulations.	A contract of the second secon	OVIDER OR SUPPLIER REEK NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The tarms of an admission contract by or o	OUDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE REEK NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE RECAT DEFICIENCY MUST BE PRECEDED BY FULL ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Continued From page 8 F 582 changes are made to the items and services specified in \$483.10(g)(17)(i)(A) and (B) of this section. F 582 S483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (ii) Where changes are made to charges for other thems and services that the facility offers, the facility must inform the resident is stay, of services not covered by Medicare and/or by the Medicaid State plan, the facility offers, the facility must inform the resident or implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must inform the resident actually resident or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident sequent and all refunds due the resident sequent and all refunds due the resident sequents of these regulations.	OUDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE REEK NURSING AND REHABILITATION CENTER 2401 WAYNE MEMORIAL DRVE BUIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) ID PRECEX TAG PROVIDERS FLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 8 changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. F 582 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and charges for those services, including any charges for services not covered under Medicaer? Medicaid or by the facility's per diem rate. F 582 (I) Where changes are made to charges for other items and services covered by Medicare and/or by the Medicaid State plan, the facility nust provide notice to residents of the change as soon as is reasonably possible. III) Where changes are made to charges for other items and services that the facility nust provide notice to resident field on the facility. The facility must inform the resident regident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident resident regident representative any and all refunds due the resident within 30 days from the resident or resident representative any and all refunds due the resident within 30 days from the resident or resident representative any and all and the facility. (v) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of di

Facility ID: 923020

If continuation sheet Page 9 of 26

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345113	B. WING		06/01/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
	REEK 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 582	Continued From page	9	F 58	32	
		ew and staff interviews the		F582	
		e the Notice of Medicare		Medicaid/Medicare Covera	age/Liability
	÷ .	ndicating the resident was		Notice	- J
		are coverage ending for 1 of		CFR(S): 483.10(g)(17)(18)(i)-(v)
		for beneficiary protection			
	notification. (Residen	it #429).		The process that lead to the	
	T I ()			was based on record revie	
	The findings included	:		interviews the facility failed	
	Resident #429 was a	dmitted to the facility on		Notice of Medicare Non-C indicating the resident was	-
	01/25/18 with diagnos	-		Medicare coverage ending	
	-	n hypercapnia, diabetes		residents reviewed for ber	
	mellitus, hypertension	n, chronic obstructive		protection notification. (Re	sident #429).
	pulmonary disease, m			All current residents received	0
	fibromyalgia, acute ki	-		under Medicare have beer	
	unsteadiness on feet.			anticipated discharge on 6	
	Resident #420 Medic	are Part A skilled services		Medicare non-coverage le issued as indicated by the	
		Resident was discharged to		Receivables Department u	
	home on 02/07/18.			Medicare Worksheet	
	Record review reveal	ed that Resident #429 was		Accounts Receivable Boo back-up Accounts Receiva	
		of Medicare Non-Coverage		Bookkeeper have been re	
	letter.			process of administering N	
				non-coverage letters at lea	
		ith the Business Office		prior to Medicare coverage	
	• • •	6/01/18 at 10:53 AM, she		6/4/18 by the Field Accour	
		st started back to work on		The Administrator will mor	
	of Non-Coverage lette	n oversight that the Notice		receiving Medicare covera weeks then monthly for 1	
	or non-coverage lette	SI WAS HULSCHU UUL.		the Daily Medicare Works	-
	During an interview w	ith the Administrator on		Receivable Bookkeeper w	
		, he stated that it was his		of Medicare non-coverage	
	-	ness Office Manager would		the beneficiary to the Adm	inistrator weekly
		edicare Non-Coverage letter		for 8 weeks then monthly	
	within 48 hours of Me	dicare Part A skilled		ensure timely provision of	
	services ending.			Administrator will check da	
				projected day of cessation	or coverage

Event ID: 7LOS11

Facility ID: 923020

If continuation sheet Page 10 of 26

		MEDICAID SERVICES					<u>). 0938-039</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
		345113	B. WING _			06	/01/2018
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
		EHABILITATION CENTER		2401 WAYNE MEMORIAL DRIVE			
	REEK NORSING AND R			G	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 582 F 641 SS=D	resident's status. This REQUIREMENT by: Based on observatio interviews the facility Minimum Data Set (M (#106) with side rails code 1 of 1 resident (Preadmission Screen (PASRR) identified as The findings included	ents of Assessments. t accurately reflect the is not met as evidenced ns, record review and staff failed to accurately code the IDS) for 1 of 1 resident as a restraint and accurately #50) to reflect Level II ing and Resident Review is a Level II PASRR. : aled Resident #106 was	F 6		 month utilizing the Daily Medicare Worksheet. The Executive QI committee will meet monthly and review audits of the Daily Medicare Worksheet for the provision of Medicare non-coverage letters and address any issues, concerns and/or trends and to make changes as needed to include continued frequency of monitoring monthly 3 months. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring relate to the plan of correction. F641 Accuracy of Assessments CFR(s): 483.20(g) The process that lead to the deficiency was based on observations, record revi and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident (#106) with sid rails as a restraint and accurately code of 1 resident (#50) to reflect Level II Preadmission Screening and Resident 	ed ew de 1	6/29/18
	admitted to the facility diagnoses which inclu Behavioral Disturband	uded Dementia with			Review (PASRR) identified as a level II PASSR.		

Facility ID: 923020

If continuation sheet Page 11 of 26

PRINTED: 07/10/2018

	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/10/20 [.] M APPROVE D. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION	(X3) DATE	E SURVEY PLETED
		345113	B. WING			06/01/2018	
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				2401 WAYNE MEMORIAL DRIVE			
WILLOW	CREEK NURSING AND F	REHABILITATION CENTER		GOL	DSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	BY FULL PREFIX (EACH CORRECTIVE ACTION SH			D BE	(X5) COMPLETIO DATE
F 641	Continued From page	e 11	F 64	41			
	Communication Defic	cit and Osteoarthritis.		ר #	The Minimum Data Set (MDS) for re #106 was modified on 6.22.18 for th	е	
	(MDS) dated 4/17/20 was severely cognitiv	rly Minimum Data Set 18 indicated Resident #106 vely impaired and required istance with all activities of		F	correct coding of the use of the side as a restraint by the MDS nurses. Resident #50 with Level II PASSR n nad Minimum Data Set (MDS)		
	were not used for the			ii F	nodifications completed on 6.8.18 for nformation needed for the Level II PASSAR by the MDS nurses.		
	Review of Resident #106's Care Plan updated/revised 1/21/18 revealed the following: Use of bed rails for maintaining current bed			C	100% audit of all current resident mo current MDS, were reviewed by the Director of Nursing (DON), the Assis		
	-	•		s (Director of nursing (ADON), the RN supervisor and the Quality Improven QI) nurses to ensure all MDS s		
	periodically and as ne			c le	completed are accurate to include a diagnosis, restraints and correct PAS evels II and are coded correctly, wa	SSAR	
	-Provide and review residents representation	odically for proper functioning with resident and or tive the risks and benefits of		A	completed on 6.21.18 using a MDS Accuracy QI tool. Any issues will be addressed and documented at that t		
		Evaluation for resident #106		e	100% in-service of the MDS nurses ensure all MDS assessments are	to	
	dated 4/17/2018 reve Cognitive ability: orie Resident has a safet	nted to person y awareness deficit		c le	completed accurately to include all diagnosis, restraints and correct PAS evels II are coded correctly on the N	/IDS	
	memory	ed short term and long-term ate impaired decision making		c 1	vas completed on 6.18.2018 by the consultant. 10% of completed MDS□s, will be		
				c t	eviewed to ensure MDS accuracy for diagnosis, restraints and PASSAR le by the ADON and/or the RN supervi	evels II sor 3	
	Provides feeling of sa	re with staff with cueing afety and/or comfort for		4 1	imes a week for 4 weeks, then wee 4 weeks and then monthly for 1 mor utilizing a MDS Accuracy QI tool. Al	ith	
	resident Risks of Side Rail us May increase potenti	e: al for injuries (skin tears,		a	dentified areas of concern will be addressed immediately by the ADOI and/or RN supervisor, by retraining	N	

Facility ID: 923020

If continuation sheet Page 12 of 26

PRINTED: 07/10/2018 FORM APPROVED

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
and plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
		345113	B. WING		06/01/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	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 OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE
F 641	injuries (laceration fra May contribute to we body in SR or betwee Alternatives/Interven none listed Recommendations: Left and right side ra The resident has req while in bed Side rails indicated a promote independen An observation of Re on 05/29/18 at 3:14 F	ial for falls and associated actures, head injuries) edging of extremity or part of en SRs tions/Recommendations- ils juested to have Side Rails and serve as an enabler to ace esident #106 was conducted PM. The resident was	F 64	 appropriate staff making the and the MDS nurse will may modifications to the MDS. review and initial the MDS tool weekly for 8 weeks and for 1 month to ensure any a concerns have been addree. The Executive QI committee monthly and review audits Accuracy tool and address concerns and/or trends and changes as needed, to incl frequency of monitoring momths. The Administrator and the responsible for the implement corrective actions to include 	ake The DON will Accuracy QI d then monthly areas of ssed. ee will meet of MDS any issues, d to make lude continued onthly 3 DON will be entation of e all 100%
	approximately 45 deg low position and bed sides of the bed. The positioned between t footboard. An observation was n 05/30/18 at 10:14 AM	the head of the bed raised grees. The bed was in the rails were observed on both be bed rails were raised and the head of the bed and the made of Resident #106 on <i>M</i> . The resident was the head of the bed raised		audits, in services, and mo to the plan of correction.	
	low position and bed sides of the bed. The positioned between t footboard. An observation and i	grees. The bed was in the rails were observed on both be bed rails were raised and the head of the bed and the nterview was completed with 5/31/18 at 8:31 AM. The			
	bed raised approximation was in the low position	ed in bed with the head of the ately 45 degrees. The bed on and bed rails were les of the bed. The bed rails			

If continuation sheet Page 13 of 26

	-	ND HUMAN SERVICES MEDICAID SERVICES				RINTED: 07/10/2018 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION		3) DATE SURVEY COMPLETED
		345113	B. WING _			06/01/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	00/01/2010
				2401 WAYNE MEMORIA	L DRIVE	
WILLOW	CREEK NURSING AND F	REHABILITATION CENTER		GOLDSBORO, NC 27	7534	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	the bed and the foott confused and unable the resident was ask she appeared unable An interview was cor Set (MDS) nurse #1 MDS nurse#1 reports #106's assessments. rails were not coded think they should be there was no other a them. MDS nurse #1 not able to request th on the assessment for resident usually was bed raised and the si the bed. An observation of Re on 5/31/2018 at 9:37 (DON), the Administr #1 were present duri resident was observe approximately raised The ½ side rails were on both sides of the B to be positioned appr the head of the bed and not care. The MDS n the electric bed to low the resident became to stop before the he approximately 30 deg lowered the side rails	e 13 tioned between the head of poard. The resident was a to state her name. When ed to hold touch the side rail, to understand the request. aducted with Minimum Data on 5/31/2018 at 8:45 AM. ed she completed Resident . MDS nurse #1 indicated the on the MDS as she did not coded as restraints and rea in the MDS to code indicated the resident was ne rails and that was an error orm. MDS #1 indicated the in bed with the head of the ide rails were at the head of esident #106 was conducted AM. The Director of Nursing rator (ADM) and MDS nurse ing the observation. The ed with the head of the bed approximately 45 degrees. e observed to be raised and bed. The rails were observed roximately ½ way between and the foot board. MDS esident if she could lower the the resident stated she did urse #1 used the control for wer the head of the bed and agitated and told the nurse ad of the bed was lowered to grees. When the bed was is automatically began to and of the bed. MDS nurse	F	541		

Facility ID: 923020

If continuation sheet Page 14 of 26

PRINTED: 07/10/2018 FORM APPROVED

	-	D HUMAN SERVICES				FORM): 07/10/2018 1 APPROVED
STATEMENT O	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345113	B. WING			06/	01/2018
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STAT	TE, ZIP CODE		
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER		2401 WAYNE MEMORIAL DR GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 641	the resident's request An interview was cond Administrator (ADM) of The ADM stated the s were coded incorrect for the assessments t 2. Resident #50 was a 11/18/15 with diagnos disorder and disorgan Review of the Annual dated on 03/21/18 ind considered by the sta Screening and Reside process to have a ser intellectual disability. screening and review determination of need appropriate care settin recommendations for individual's plan of ca Review of Resident's Determination Notifica revealed that the reside number. During an interview w on 05/31/18 at 1:25 P	k to the prior position per ducted with the on 5/31/2018 at 9:44 AM. ide rails for resident #106 y and his expectation was o be coded accurately. admitted to the facility on ues of major depressive ized schizophrenia. Minimum Data Set (MDS) licated the resident was not te Level II Preadmission ent Review (PASRR) ious mental illness and/or The results of this are used for formulating a l, determination of an ng and a set of services to help develop an re. #50 PASRR Level II ation dated on 05/14/12	F 641				
		ith the MDS Coordinator on					

Facility ID: 923020

If continuation sheet Page 15 of 26

	F DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		345113	B. WING		06/01/2018	
NAME OF P	ROVIDER OR SUPPLIER	L	ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
	REEK NURSING AND R	EHABILITATION CENTER	24 G			
(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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLE	
F 641	Continued From page	e 15	F 641			
	05/31/18 at 4:28 PM,	she stated that this resident				
	was not on the list of residents that were PASRR					
		ordinator further stated the of Level II PASRR residents.				
		JI LEVELITI ASIAIA TESIGENIS.				
	•	ith the Administrator on				
	06/01/18 at 4:37 PM,					
	the MDS.	acility staff accurately code				
F 655			F 655		6/29/18	
SS=D	CFR(s): 483.21(a)(1)	-(3)				
	8483 21 Comprehens	sive Person-Centered Care				
	Planning					
	§483.21(a) Baseline Care Plans					
		cility must develop and care plan for each resident				
		uctions needed to provide				
		centered care of the resident				
		al standards of quality care.				
	The baseline care pla (i) Be developed with	in Must- in 48 hours of a resident's				
	admission.					
		um healthcare information				
	necessary to properly including, but not limit					
		l on admission orders.				
	(B) Physician orders.					
	(C) Dietary orders.(D) Therapy services.					
	(E) Social services.					
		endation, if applicable.				
	§483.21(a)(2) The fac	cility may develop a				
	comprehensive care	plan in place of the baseline				
	care plan if the comp					
		n 48 hours of the resident's				
	admission.					

Facility ID: 923020

If continuation sheet Page 16 of 26

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	· · ·	MPLETED
		345113	B. WING		a	6/01/2018
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP O		0.0
				2401 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND F	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 OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 655	Continued From page	- 16	Ге			
1 000			F 65	50		
		ments set forth in paragraph cepting paragraph (b)(2)(i) of				
		cility must provide the				
		presentative with a summary				
		plan that includes but is not				
	limited to: (i) The initial goals o	f the regident				
		e resident's medications and				
	dietary instructions.					
	(iii) Any services and	I treatments to be				
		acility and personnel acting				
	on behalf of the facili					
		rmation based on the details				
	This REQUIREMENT	e care plan, as necessary. 「 is not met as evidenced				
	by:			5055		
		n, staff interview and record		F655		
	a feeding tube within	led to provide a care plan for		Baseline Care Plans		
	-	one residents reviewed with		CFR(s): 483.21(a)(1)-(3)		
	a feeding tube (Resid			The process that lead to th	e deficiency	
				was based on observation		
	Findings included:			and record review, the faci		
	-			provide a care plan for a fe	-	
		cal record revealed Resident		within forty-eight hours of a		
		/21/2018 with a diagnosis of		one of one residents review		
		The medical record noted		feeding tube (Resident #29	99).	
	placement of a feedir	ng tube on 5/15/2018.				
				100% audit of baseline car		
		num Data Set (MDS) dated		residents, to include reside		
		ident #299 to be cognitively tensive assistance for all		were admitted to the facilit days were reviewed by the		
		ng (ADLs), with the physical		Nursing (DON), the Assista		
	-	rson. The MDS noted the		nursing (ADON), the RN si		
		d more that 51% of total		the Quality Improvement (
	calories to Resident			ensure all areas of care, to		

Facility ID: 923020

If continuation sheet Page 17 of 26

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		345113	B. WING		06/01/2018
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP 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 OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETIO
F 655	and this area would g A review of Resident no care plan for a fee On 6/1/2018 at 2:39 nurse assigned to Re feeding was left off o plan, but would be in care plan due 6/3/20 On 6/1/2018 at 3:30 stated her expectation	go to care plan. #299's care plan revealed eding tube. PM, in an interview, an MDS esident #299 stated the tube of the forty-eight hour care icluded in the twenty-one day 18. PM, the Director of Nursing on was if a resident was ing tube, it would be care	F 65	 initial care plan and will be completed to be revised will be updat the Minimum Data Set (MDS) nur an updated care plan would be git the resident and/or the resident representative (RR) by the MDS moreating and implementing the resident and completed by 6.19.2018. 10% of completed baseline care plan will be conduct the facilities MDS consultant and completed by 6.19.2018. 10% of completed baseline care plate reviewed by the Assistant Dire nursing (ADON), the RN supervisions the Quality Improvement (QI) nurse ensure all areas of care, to includ feeding tubes, were care planned initial care plan 3 times a week for weeks, then weekly for 4 weeks a monthly for 1 month utilizing Base Care Plan Audit tool. The DON wand initial the Baseline Care Plan tool weekly for 8 weeks and then for 1 month to ensure any areas of concerns have been addressed. The Executive QI committee will monthly and review audits of Base Care Plan Audit tool and address issues, concerns and/or trends ar make changes as needed, to includ frequency of monitoring monthly for 3 months. The Administrator and the DON wand the for 3 months. 	n that ted by se and ven to hurse. urse on sident ted by will be blans will ctor of or and ses to e on the r 4 und then eline rill review Audit monthly of meet eline any nd to ude o

Event ID: 7LOS11

Facility ID: 923020

If continuation sheet Page 18 of 26

	S FOR MEDICARE &				OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345113	B. WING		06/01/2018
NAME OF PF	ROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
	REEK 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 655	Continued From page	e 18	F 655		
F 609	Dielysia		E 609	to the plan of correction.	6/20/19
F 698 SS=D	Dialysis CFR(s): 483.25(l)		F 698		6/29/18
	require dialysis receiv with professional star comprehensive perso the residents' goals a This REQUIREMENT by: Based on record rev staff and resident inter monitor a dialysis res failed to provide nurs resident after dialysis provide ongoing com	is not met as evidenced iew, observations and facility erviews, the facility failed to idents access/shunt site, ing assessments for a treatments and failed to munication documentation center for 1 of 1 residents		F698 Dialysis CFR(s): 483.25(I) The process that lead to the deficiency was based on record review, observat and facility staff and resident interview the facility failed to monitor a dialysis residents access/shut site, failed to provide nursing assessments for a	ions
	Record review reveal admitted to the facility diagnoses which inclu			resident after dialysis treatments and failed to provide ongoing communication documentation with hemodialysis cent for 1 of 1 residents reviewed for dialys (Resident #72).	er
	(MDS) dated 4/6/201 was severely cognitiv extensive assistance living. The MDS indic	ecent Minimum Data Set 8 revealed Resident #72 rely impaired and required with all her activities of daily ated the resident required mes a week for End Stage		100% audit was completed on 6.4.18 H the Director of Nursing (DON), the Assistant Director of Nursing, the Qual Improvement (QI) nurses, the RN supervisor, and Staff Facilitator for all residents, to include resident #72, receiving dialysis treatment to ensure the shunt site is being checked daily for	lity
	Review of Resident #	72's care Plan initiated		the bruit and thrill per documentation c	

Facility ID: 923020

If continuation sheet Page 19 of 26

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION		O. 0938-03 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	• • •	G	· · ·	COMPLETED	
		345113	B. WING		06	6/01/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE			
				2401 WAYNE MEMORIAL DRIV	/E		
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	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETIO DATE	
F 698	Continued From page	- 10	F 69				
1 030			FO				
	Stage Renal Disease			(MAR) and if not on the			
	-	dialysis. The Care Plan		placed on the MAR fo			
	interventions included	ys and Fridays, assessment					
	of the resident upon r			every shift daily and to an assessment prior t			
	-	cation with dialysis center		leaving the facility for			
		n care or treatment plan and		and that the Dialysis p	-		
	to monitor dialysis sit			residents electronic re	-		
				completed on the resi	•		
	An observation of Re	sident #72 was conducted		receiving dialysis treat			
	on 5/29/2018 at 11:18	8 AM. The resident was		Initial Dialysis Review	-		
	observed to be seate	d in a wheelchair beside the		will be addressed at the			
	bed in her room. The	resident reported she went		Director of Nursing (D	ON), the Assistant		
	to dialysis three times	s a week. The resident also		Director of Nursing, th	e Quality		
	reported the dialysis	treatments were completed		Improvement (QI) nur			
		er right arm. The resident		supervisor, and/or Sta	aff Facilitator.		
		there what appeared to be					
		alysis shunt is a connection		100% in-service was i			
	-	to allow a high blood flow for		the Staff Facilitator for			
	dialysis).			to include nurse #4 ar			
				include agency nurses			
		ation Administration Records		checking the bruit and			
		Iministration Records for month of May 2018 revealed		daily and documenting results. That the resid	-		
		the shunt site. There was		nurse will complete ar	-		
		the electronic medical		resident, to include ch			
		s/assessments for the shunt		site, to include the bru	•		
	site.			documentation of the			
				resident⊡s electronic			
	An interview was con	ducted with Nurse #3 on		resident returns to the			
		rse #3 confirmed she was		dialysis treatment that			
	the nurse who worked	d with resident #72 during		assigned nurse will co			
	the day shift. Nurse #	3 indicated she checked the		progress note in the re			
		sure and would send the		record that includes; t			
	Medication Administra			returned from dialysis			
		to the dialysis center on the		shunt site (dressing in	-		
		s transported to dialysis.		drainage, etc.), Bruit &			
		e other residents who		Condition & Mental st			
	I reading dialugia had	a communication book that	1	oriented, confusion, le	tharay other	1	

Facility ID: 923020

If continuation sheet Page 20 of 26

		MEDICAID SERVICES				IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY IPLETED
		345113	B. WING		0	6/01/2018
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
WILLOW	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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 698	Continued From page	e 20	F 69	8		
	 ³ Continued From page 20 was sent with them but Resident #72 did not. Nurse #3 stated she did not know why the resident did not have a communication book. Nurse #3 indicated she was not sure if the resident had a shunt because the resident usually returned after her shift was completed. Nurse #3 stated she did not check a shunt site on Resident #72's non-dialysis days. An interview was conducted with the Quality Improvement (QI) nurse on 5/31/18 2:56 PM. The QI nurse indicated she was familiar with resident #72. The QI nurse stated each dialysis resident was supposed to have a dialysis communication book that was to be sent to the dialysis center 			symptoms, etc.), Instruction communication from dialysis wts, lab results, etc.), and a comments (time dressing re- notification and orders chan etc.). The inservice will be o 6.26.18. All residents receiving dialys to include resident #72, will by the Assistant Director of Quality Improvement (QI) m supervisor, and Staff Facilita that the residents shunt is b for the bruit and thrill every	s ctr (pre/post dditional emoved, MD iges/verified, completed by sis treatment, be reviewed Nursing, the urses, the RN ator to ensure eing checked	
	the book contained in resident's condition a treatment and docum staff of the resident's The QI nurse stated s resident #72 did not h The QI nurse also inc responsible for makin had the books availab	nent. The QI nurse revealed formation regarding the t the facility before the eentation from the dialysis condition after treatment. she did not know why have a communication book. dicated she was the one of sure the dialysis residents ble. The QI nurse also stated assessment in the nurses'		that it is documented on the MAR, that there is an asses the resident leaving the faci treatment and that the Dialy note in the residents electro being completed on the resi from receiving dialysis treat Follow Up Dialysis Review week for 4 weeks, then wee weeks and then monthly for Director of Nursing will revie	sment prior to lity for dialysis rsis progress onic record is idents return ment utilizing a Tool, 3 times a skly for 4 1 month. The	
	and after dialysis and Medication Administra shunt site assessmen stated she did not kno not in the medical rec An interview was con	ducted with Nurse #5 on		the Follow up Dialysis Revie for 8 weeks then monthly fo completion and to ensure all areas of concern were addr The Executive QI committee monthly and review audits of up Dialysis Review tool and issues, concerns and/or tree make changes as needed, t	ew Tool weekly r 1 month for II identified essed. e will meet of the Follow address any nds and to to include	
	with Resident #72 on was familiar with her	rse #5 reported she worked the 3PM to 11PM shift and needs. Nurse #5 indicated from dialysis treatments		continued frequency of mon monthly for 3 months. The Administrator and the D responsible for the impleme	OON will be	

Facility ID: 923020

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MELLTIDI	E CONSTRUCTION		D. 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		· · ·	PLETED
		345113	B. WING		06	/01/2018
IAME 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 698	during the 3PM to 111 she thought she chec	e 21 PM shift. Nurse #5 stated ked the resident's shunt site urned from dialysis. Nurse	F 698	3 corrective actions to include all 100 audits, in services, and monitoring to the plan of correction.		
	#5 stated if she check document the assess Nurse #5 indicated if in the notes she may site. Nurse #5 reporte supposed to have a c	the site she would ment in the nurses' notes. there was no documentation have forgotten to assess the ed all dialysis residents were lialysis communication book remembered looking at				
F 880 SS=C	Nursing (DON) on 5/3 stated the facility exp residents to be asses assessed post dialysi assessed every shift. assessments should stated the facility exp dialysis residents to h communication book communication for an the dialysis center sta Infection Prevention 8	be documented. The DON ectation also included all lave a dialysis to ensure there was by issues documented from aff. & Control	F 880			6/29/18
33=0	§483.80 Infection Con The facility must esta infection prevention a designed to provide a comfortable environm	ntrol blish and maintain an ind control program i safe, sanitary and ient and to help prevent the ismission of communicable				
	§483.80(a) Infection program.	prevention and control				

Facility ID: 923020

If continuation sheet Page 22 of 26

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	: 07/10/2018 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMPI	SURVEY
		345113	B. WING			06/0	01/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE	, ZIP CODE		
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER		401 WAYNE MEMORIAL DRIV GOLDSBORO, NC 27534	Έ		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 880	and control program (a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable dis staff, volunteers, visito providing services und arrangement based u conducted according accepted national stat §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whom communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the ir involved, and (B) A requirement tha least restrictive possible circumstances. (v) The circumstances	blish an infection prevention IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other in possible incidents of se or infections should be ensmission-based precautions ent spread of infections; blation should be used for a t not limited to: attion of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable cin lesions from direct a or their food, if direct	F 880				

Facility ID: 923020

If continuation sheet Page 23 of 26

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/10/201 FORM APPROVE OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345113	B. WING		06/01/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 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 OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 880	Continued From non	- 00	_			
F 00U			F 880			
		e procedures to be followed irect resident contact.				
	§483.80(a)(4) A syst	em for recording incidents				
		acility's IPCP and the				
	corrective actions tal	ken by the facility.				
	§483.80(e) Linens.					
		dle, store, process, and				
		s to prevent the spread of				
	infection.					
	§483.80(f) Annual re	view.				
		uct an annual review of its				
	IPCP and update the	eir program, as necessary.				
		T is not met as evidenced				
	by:			5000		
		ons, record reviews, and staff		F880		
		y failed to wear gloves during insulin and the removal and		Infection Prevention and Control		
		h for one of one resident		CFR(s): 483.80(a)(1)(2)(4)(e)(f)		
		ulting in a possible staff				
		a bloodborne pathogen and		The process that lead to the deficient	cv	
	reception of the med			was based on observations, record	,	
	absorption.			reviews, and staff interviews, the faci	lity	
				failed to wear gloves during the		
	Findings included:			administration of insulin and the remo		
	-	in-service entitled "Infection		and application of a patch for one of a		
	-	Medication Administration, of PPE" dated 05/02/18 was		resident (Resident #169) resulting in possible staff member exposure to a	a	
		gloves were to be worn		blood borne pathogen and reception	of	
		d procedures that they may		the medication through the skin.	-	
		ds. This included performing		100% medication pass audit was initi	ated	
	ADLs (activities of da	aily living) such as mouth		on 6.1.18 with all license nurse, to inc		
		rineal (genital area). Also, it		agency nurses, and medication aides	s by	
	-	b be worn during medication		the Director of nursing (DON), the		
		inistering injections, eye		Assistant Director of nursing (ADON)		
		inhalers and removing or		RN supervisor, the Staff Facilitator, a		
	applying patches.			the Quality Improvement (QI) nurses		

Facility ID: 923020

If continuation sheet Page 24 of 26

	S FOR MEDICARE &				OMB NO. 0938-03	
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345113			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING		06/01/2018		
NAME OF PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
			2401 WAYNE MEMORIAL DRIVE			
	CREEK NORSING AND R	REHABILITATION CENTER		GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION	
F 880	Continued From page	e 24	F 880			
F 000	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		F 880 proper medication administration to include wearing gloves when administering injections and apply medication patches to ensure prop medication administration utilizing Medication Pass audit form. Any i identified during the medication pa- was immediately corrected with re- of the license nurse, to include age nurses, and/or medication aide by DON, ADON, RN supervisor, Staff Facilitator, and the QI nurses and completed by 6.26.18. 100% in-service was initiated on 6 all licensed nurses, to include age nurses, and medication aides by th Facilitator regarding appropriate medication administration to include wearing gloves when applying mer patches and giving injections and y completed by 6.26.18. All newly finurses, to include agency nurses, medication aides will be in-service Staff Facilitator on appropriate mer administration to include the weari gloves when applying medication part and injections. The Medication Pass Audit Tool wi utilized by the ADON, RN supervis Facilitator, and the QI nurses 2 tim week for 4 weeks; then weekly for weeks; then monthly for 1 month to ensure each hall nurse to include a nurses, and medication aides is in		Deriver Date Deriver Date Date Deriver Date Deriver Date Deriver Date Deriver Date Deriver Date Deriver Date Deriver Date Deriver Date Deriver Date	

Facility ID: 923020

If continuation sheet Page 25 of 26

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345113			(X2) MULTIPI A. BUILDING	· · ·	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		245112	B. WING				
		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	•	01/2018		
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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	HOULD BE COMPLETION	
F 880	Coordinator) who also Infection Control Prog working at the facility stated Infection Contr hire classes. The SD was an agency (temp attended a training or 05/02/18. She stated control measures, she using proper PPE (Pe Equipment) during me	a.m. an interview was DC (Staff Development o oversaw the facility's gram. She stated she began on March 1, 2018. She rol was taught in her new C stated although the LPN horary help) nurse, she in Infection Control on I in addition to other infection e taught the importance of	F 88	the licensed nurse or medication any identified issues observed medication pass audits by the supervisor, Staff Facilitator, an nurses. The DON will review a the Medication Pass Audit Too appropriate medication admini residents to include resident # compliance and to ensure all id areas of concern were address for 8 weeks, then monthly X1 r The Executive QI committee w monthly and review audits of th Medication Pass Audit Tool an- any issues, concerns and/or tr make changes as needed, to i continued frequency of monito monthly 3 months. The Administrator and the DOI responsible for the implementa corrective actions to include al audits, in services, and monito to the plan of correction.	during the ADON, RN ad the QI and initial I for stration to 169 for dentified sed weekly month. vill meet he d address ends and to nclude ring N will be ation of I 100%		

Facility ID: 923020

If continuation sheet Page 26 of 26