PRINTED: 03/27/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345113	B. WING		02/22/2019
	ROVIDER OR SUPPLIER CREEK NURSING AND F	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	1 02/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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 COMPLETION
E 000	Initial Comments		E 00	0	
F 565 SS=E	conducted on 02/18/2 facility was found in or requirement CFR 483 Preparedness. Even Resident/Family Gro	3.73, Emergency t ID # 9ZO511. up and Response	F 56	5	3/22/19
	\$\frac{483.10(f)(5)(i)-(iv)(6)(7)}\$ \$\frac{483.10(f)(5)}{483.10(f)(5)}\$ The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. \$483.10(f)(6) The resident has a right to participate in family groups.				
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	 RF	TITLE	(X6) DATE

Electronically Signed 03/15/2019

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.

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345113	B. WING _			02/	22/2019
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	ı OZI	22/2010
				2401	I WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND R	REHABILITATION CENTER			LDSBORO, 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 565	Continued From page	e 1	F 5	565			
	· -	ident has a right to have					
	family member(s) or o						
	*	et in the facility with the					
	families or resident representative(s) of other						
	residents in the facilit						
	This REQUIREMENT	is not met as evidenced					
	by:						
	Based on Resident C			Willow Creek Nursing and Rehabilitation	on		
	interviews and staff in			Center acknowledges receipt of the			
	make prompt efforts t	-			Statement of Deficiencies and propose		
		gh staff and staff being			this Plan of Correction to the extent tha	ıt	
		passed on first and second paths on third shift, that were			the summary of findings is factually correct and in order to maintain		
		esident Council Meetings for			compliance with applicable rules and		
		nts who previously voiced		- 1	provisions of quality of care of residents	s.	
	grievances in Resider			1 -	The Plan of Correction is submitted as		
		ent #94 and Resident #142).		'	written allegation of compliance.		
	The findings included	:			Willow Creek Nursing and Rehabilitatio Center response to this Statement of	n	
	Review of Resident C			- 1	Deficiencies does not denote agreemer	nt	
	December, 2018 thro	- ·			with the Statement of Deficiencies nor		
		such as not enough aides		- 1	does it constitute an admission that any	y	
	•	espectful had not been		- 1	deficiency is accurate. Further, Willow		
		e meetings, no ice water		- 1	Creek Nursing and Rehabilitation Center	er	
	=	ad not been responded to			reserves the right to refute any of the		
	_	d not getting baths on third sponded to for two meetings.		- 1	deficiencies on this Statement of Deficiencies through Informal Dispute		
	Siliit nau not been les	sponded to for two meetings.			Resolution, formal appeal procedure		
	During a Resident Co	ouncil Meeting held on			and/or any other administrative or legal		
	•	Resident #33 said he was			proceeding.		
		third shift and it happened		'			
	•	Resident #142 and Resident			F 565 Resident/ Family Group and		
		ere not enough aides and			Response		
		espectful. Resident #94 and		(On 3/13/19, the Resident Liaison		
		ed response to call lights		- 1	interviewed Resident #33 and discusse		
		one hour for someone to			the concern related to not receiving a b	ath	
		staff person would turn out would be back. Resident			on third shift to ensure concerns were resolved. Resident #33 stated the		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245442	B. WING				0
		345113	B. WING _			02/	22/2019
NAME OF PR	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
WILL OW (REEK NURSING AND R	REHABILITATION CENTER		24	101 WAYNE MEMORIAL DRIVE		
WILLOW (OKEEK NOKOMO AND K	ELIABLETATION SERVER		G	OLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD E			(X5) COMPLETION DATE
F 565	#142 and Resident #94 revealed there were not enough staff on the halls to provide care. Resident #94 and Resident #33 revealed they were supposed to get baths on third shift and sometimes they had to wait until the next morning to get a bath. During an interview on 2/20/19 at 4:18 PM, the facility Activity Director said the Resident Liaison was usually in the meetings to get all of the resident group concerns. The Activity Director said the Activity Assistant would sometimes takes notes for the meeting and the Resident Liaison		F 5	565	concerns had been addressed. On 3/13/19, the Resident Liaison interview Resident # 142 and Resident # 94	ed	
					regarding not enough aids, aids being disrespectful, call light response, not enough staff on the halls to provide car and receiving baths on third shift to		
					ensure concerns were resolved. Reside #142 and resident #94 both stated that concerns had been addressed. On 3/14/19, the Resident Liaison		
					reviewed all resident council meeting minutes for the past 4 months from		
	Resident Liaison was	e concerns. She said the at the Resident Council but she did not attend the			November 2018- February 2019 to incl not enough aids, aids being disrespect call light response, not enough staff of	ful,	
	was on leave of abse	nd February because she nce. The Activity Director			halls to provide care and receiving bath on third shift to. This audit was to ensure the facility resolved grisy spaces valided.	ure	
		eard anything about staff residents and not having			the facility resolved grievances voiced in the resident council meeting. Any identified areas of concern or grievance that were not resolved were written on	es	
	Resident Liaison said	n 2/21/19 at 1:49 PM the I depending on the nature of Id personally follow up on			grievance form and investigated and resolutions by the Resident Liaison by 3/15/19.	u	
	them. She said she we concerns about no ice	ould follow up on the e water as she was walking			On 2/21/19, the Administrator initiated a in-service for the Activity Coordinator,		
	the grievances so she	ed she never got some of e was not able to follow up e had been out on leave of			Resident Liaison, Director of Nursing, F Supervisors, Maintenance, Dietary Supervisors, Therapy Manager, Social	KN	
	absence.				Workers, Housekeeping Supervisor, ar Business Office Manager (Department		
	facility Social Worker	n 2/21/19 at 3:44 PM, the , SW#2 stated she ed grievances and forwarded			Managers) on Resident Council Meetin and voiced concerns, which included: 1 The facility must consider the views of)	
	them to the Director of She stated she did no	of Nursing and Administrator. ot recall any descriptions of			resident or family group and act prompupon the grievances and		
	_	ally or physically abused. She inservices on how to treat			recommendations of such groups concerning issues of resident care and	life	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345113	B. WING				22/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 021	22/2019
14/11 1 014/	DEEK NUDOWO AND E	SELLA DIL ITATIONI GENITED		24	01 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND F	REHABILITATION CENTER		G	OLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565	Continued From page	e 3	F 5	565			
F 565	During an interview w Director of Nursing (I the Administrator revolute the resident grid Resident Council Me		F	565	in the facility. 2) When there are resider council minutes or interviews that residents voice concerns or grievances the grievance should be written on a resident council concern form and give to the Resident Liaison. The Resident Liaison will ensure that the grievance is logged on the grievance log and forward the grievance to the appropriate department manager to ensure the grievance is addressed, responded to, and promptly resolved in a timely mann 3) The resolution will be discussed and documented at the next resident council meeting. This in-service was complete on 3/15/19 by the Administrator. The Administrator and/or DON will reviresident council minutes and Resident Council concerns that were voiced to include residents # 33, # 94 and #142 utilizing the Resident Council Audit Toomonthly for 3 months. This audit is to ensure that grievances have been writt on a resident council grievance form an promptly resolved that were voiced dur the resident council meetings. The Administrator and/or Director of Nursin will reeducate the Department Manage to ensure that all grievances are resolv promptly for areas of identified concern. The Administrator will forward the Resident Council Audit Tools to the Executive QA Committee monthly x 3 months. The Executive QA Committee review the Tools monthly x 3 months to	n s rd ner. d sil de ew el ren d sing g rs ed es. will	
					review the Tools monthly x 3 months to determine trends and / or issues that m need further interventions put into place	nay	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345113	B. WING _				22/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 02/	22/2013
WILL OW (DEEK MUDEING AND I	DELIABILITATION CENTED		240	01 WAYNE MEMORIAL DRIVE		
WILLOW	KEEK NURSING AND I	REHABILITATION CENTER		GC	DLDSBORO, 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 SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 565	Continued From pag	e 4	F 5	565	and to determine the need for further a / or frequency of monitoring.	nd	
F 604 SS=D	Right to be Free from CFR(s): 483.10(e)(1)		F 604			3/22/19	
	§483.10(e) Respect a The resident has a rigand dignity, including	ght to be treated with respect					
	§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.						
	§483.12(a) The facili	ty must-					
	§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by:						
	Based on observation	ons, record reviews and staff			F 604 Right to be Free from Physical		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(C
		345113	B. WING			02/	22/2019
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				2	401 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND R	REHABILITATION CENTER			GOLDSBORO, NC 27534		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 604	Continued From page	e 5	F 604				
	· -	failed to provide a medical			Restraints		
		ampled residents reviewed			On 2/20/2019, a doctor s order was		
	with a bed rail restraint. (Resident #60).				written for Resident #60 bilateral side ra	ails	
		(. 100.00.11 // 00).			with a medical symptom for bedrail		
	The findings included	l:			restraint by the Minimum Data Set Nurs (MDS).	se	
	Resident #60 was ori			On 3/14/19, the MDS Coordinator			
	on 10/5/18, with diag			reviewed 100 % of all residents to inclu	ıde		
	disease, Hypertensio			Resident # 60 with restraints including	bed		
	(Generalized) and Alt				rail restraints to ensure that all resident	.s	
		t recent Quarterly Minimum			have a doctor s order with a medical		
		d 1/4/19, Resident #60 was			symptom for the restraint. There were r	10	
	cognitively impaired.			other identified areas of concern.			
		bility and transfers. Review			On 3/15/19, the Director of Nursing		
		its and alarms) on the MDS			initiated an in-service for 100% of nurse	3 S	
		0 was coded for bed rail			regarding: all residents must have a	_	
	restraints (used daily)).			doctor sorder with a medical sympton for a restraint. This in-service will be	11	
	Review of Resident#	t60's medical record			completed by 3/22/19.		
	revealed there was n				completed by 3/22/13.		
	medical symptom for				The RN Supervisors will review 10 % o	f all	
	modical cymptom for	bod ram roomanno.			residents to include Resident # 60 with		
	Resident #60's care r	olan goal dated 10/5/18,			restraints including bedrails weekly X 8		
		ressed use/application of			weeks then monthly X 1 month utilizing		
		rice (side rails) for prevention			the Restraint Audit Tool. This audit is to		
	of injury to self or to o	others characterized by high			ensure that all residents with restraints		
	risk for injury/falls, im	paired mobility and physical			have a doctor s order with a medical		
	aggression related to	cognitive impairment.			symptom for the restraint. The Director	r of	
	Interventions included	d evaluate for least			Nursing will reeducate the nurses and		
		and/or discontinuation per			obtain a clarification doctors order with		
		valuate for underlying			medical symptom for any identified are		
	causes for potential b				of concern during the audit. The Direct	or.	
	unsteady gait and en	vironmental barriers.			of Nursing will review and initial the		
					Restraint Audit Tool weekly x 8 weeks		
		evised date 12/28/18, also			then monthly x 1 month for completion		
		d rails for increasing or			and to ensure all areas of concern were	e	
	_	ed mobility and/or transfer			address.	ſ	
	noted for the previous	not revised on 2/20/19 as			The Director of Nursing will forward the	_	
	LIOLEGIOLINE DIEVIOUS	a guar illiciyetii(UIS	1		THE DIECULOLINGISHO WILLOWARD INC	.= '	1

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345113	B. WING _				22/2019
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		<u>, </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 604	from bed rails periodic Check bed rails periodic functioning, ensure be appropriate for reside installed and maintain recommendations, and evice periodically for and appropriateness. The resident and or family and benefits of the usurails to assist resident and exit the bed at his level. During an observation Resident #60 was lying room. His bed was lown attress was on the bed rails up on his bed rails up. The resident #60 was lying raised, bed rails up. The raised and the mattress of that the NA could resident. During an interview of Nursing Assistant (North did not try to get out of liked to let his legs has the bed rails were us and hit the floor. She pull up and slide on the recently tried to get up.	dent for risk of entrapment cally and as necessary. dically for proper ed dimensions are ent, ensure bed rails are ned per manufacturer's not evaluate use of the recontinued effectiveness. Provide and review with representative the risks se of bed rails. Use of bed to increase ability to enter ghest practicable mobility. In on 2/20/19 at 12:08 PM, not on 12/20/19 at 12:08 PM, not on 12/20/19 at 12:13 PM, not on 12/20/19 at 12:24 PM, not on 12/20/	F	604	Restraint Audit Tools to the Executive Committee monthly x 3 months. The Executive QA Committee will review th Tools monthly x 3 months to determine trends and / or issues that may need further interventions put into place and determine the need for further and / or frequency of monitoring.	e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345113	B. WING		C 02/22/2019		
	ROVIDER OR SUPPLIER CREEK NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	1 OLIZEIZOTO		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION		
F 604	was not sure the resolve said the bed rate. She said the bed rate. She said the bed rate. She said the because he was a for bed by himself. During an interview Nurse #13 revealed on his bed to keep 1 She said he had nowhile she worked. During an interview Nurse #12 stated R mattress on the floor would try to get up a stated Resident #60 was to unassisted and the intervention. Staff N on Resident #60's because #12 said the Resident #60 to pul assist staff in position During an observati Resident #60 was ly was lowered to the the floor next to his his bed.	inititing the floor. She said she ason the bed rails were used. ils were always up on his bed. on 2/20/19 at 3:55 PM, NA #60 had bed rails on his bed all risk and had tried to get out on 2/20/19 at 4:00 PM, Staff Resident #60 had bed rails nim from rolling off the bed. to rolled or fallen out of bed on 2/21/19 at 8:30 AM, Staff esident #60 had a full or next to his bed because he and had a couple of falls. She o's bed was kept in the lowest ne was in his room. She stated rying to get out of bed mattress on the floor was an lurse #12 stated the bed rails ned were used for safety, to lling out of bed. She stated he is off the end of his bed. Staff bed rails were also used for I himself up in bed or help to	F 604				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE COMP	SURVEY LETED
		345113	B. WING				22/2019
	ROVIDER OR SUPPLIER CREEK NURSING AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		IOULD BE		(X5) COMPLETION DATE
F 623 SS=C	because of impaired of behavior and he would When the MDS Nurse she had not complete prior to coding the be revealed that was sor rectify as well as the or During an observation Resident #60 was lying was on the floor next bed was lowered to the were up on his bed. During an interview word (DON) and Administrated the DON revealed he plan restraints, have a diagnosis, the need for policy and protocol. Notice Requirements CFR(s): 483.15(c)(3) Notice Before a facility transpresident, the facility more representative (s) of the reasons for the manguage and manner facility must send a corepresentative of the Long-Term Care Ombedischarge in the resident representative of the Long-Term Care Ombedischarge in the resident representative of the Long-Term Care Ombedischarge in the resident resident representative of the Long-Term Care Ombedischarge in the resident resident resident representative of the Long-Term Care Ombedischarge in the resident resident resident resident resident reasond discharge in the resident residen	es for bed rail restraints was cognition and combative diget out of bed unassisted. He was asked the reason and a bed rail assessment diget rails as a restraint, she mething she was trying to doctor's order. In on 2/22/19 at 9:30 AM, and awake in bed. A mattress to his bed. The resident's are floor and half bed rails with the Director of Nursing attor on 2/22/19 at 10:00 AM, are expectation was to care a doctor's order per for the restraint and to follow the restraint and to follow before transfer. Fers or discharges a mustand the resident's are transfer or discharge and ove in writing and in a rethey understand. The opy of the notice to a Office of the State budsman.		623			3/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345113	B. WING		C 02/22/2019		
	ROVIDER OR SUPPLIER CREEK NURSING AND F	REHABILITATION CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	02/22/20:0		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 623	paragraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specifie (c)(8) of this section, discharge required under by the facility a resident is transferred (ii) Notice must be must be fore transfer or dis (A) The safety of individe endangered under this section; (B) The health of individe endangered, under this section; (C) The resident's heallow a more immediated under paragraph (c)((D) An immediate transferred by the residunder paragraph (c)((E) A resident has not days. §483.15(c)(5) Content of the following the following the following the following the following the name, a and telephone number receives such requesting the following the followin	of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be at least 30 days before the d or discharged. ade as soon as practicable charge when-viduals in the facility would be paragraph (c)(1)(i)(C) of viduals in the facility would be paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; ansfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or at resided in the facility for 30 and the facil	F 623				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345113	B. WING		C 02/22/2019	
	ROVIDER OR SUPPLIER CREEK NURSING AND F	REHABILITATION CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	, 02/22/20/10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 623	hearing request; (v) The name, addrest telephone number of Long-Term Care Omit (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and accepto developmental disab C of the Developmental disable of the protection of the Mentally III of the disability of the information in the effecting the transfer must update the recipal practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the State Survey A State Long-Term Carthe facility, and the rewell as the plan for the well as the plan for the case of the plan for the well as the plan for the case of the plan for the well as the plan for the case of the plan for the well as the plan for the case of the plan for the well as the plan for the case of the plan for the well as the plan for the plan for the case of the plan for the well as the plan for the	and submitting the appeal as (mailing and email) and the Office of the State budsman; by residents with intellectual isabilities or related ag and email address and the agency responsible for livocacy of individuals with illities established under Part atal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental asabilities, the mailing and lephone number of the or the protection and als with a mental disorder a Protection and Advocacy luals Act.	F 623			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345113	B. WING _				22/2019
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 021	22/2019
					01 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER			DLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 623	by: Based on record revifacility failed to notify responsible party in water residents (Residents discharged to the host of the findings included to the findings and readmitter including Acute Renathypertrophy, Anemia Dementia. A review of Resident Data Set (MDS) dated having severely impact A review of Resident revealed he was sent evaluation due to increased and renal failure. He 1/9/19. No written not documented to have resident or his resport In an interview on 2/2 revealed when sending hospital, she would seprofile page, MAR (more record), medications stated she thought the	is not met as evidenced iew and staff interviews, the the family member or writing when 4 of 4 sampled # 117, 98, 87 and 135) were spital. s admitted to the facility on ed on 1/9/19 with diagnoses I Failure, Benign Prostate Hypertension, and #117's annual Minimum d 1/23/198 identified him as ired cognition. # 117's medical record to the hospital on 1/1/19 for reased temperature of 101.2 returned to the facility on tice of transfer was been provided to the	F6	623	F 623 Notice Requirements Before Transfer/Discharge On 3/14/19, written notification of the transfer/discharge to include the reasor for the transfer/discharge to include the reasor for the transfer/discharge to the hospita was provided to the Resident/ Residen Representative by the Social Worker for Residents # 117, # 98, #87, #135. 100% audit of current residents transfer/discharges x 30 days to includ Resident # 117, # 98, # 87, #135 was completed by the Social Worker to ens resident and/or resident representative received written notification of the transfer/discharge to include the reasor for the transfer/discharge when transferred to the hospital/discharge from the facility. During the audit, all areas of concern were addressed by the Social Worker by providing written notification the policy on 3/14/19 by certified mail. On 2/21/19, an in-service was initiated with all social workers by the Administr regarding providing written notification the Resident/ Resident Representative the Notice of Transfer/Discharge before/upon hospital transfer with documentation in the clinical record. A newly hired social workers will receive in-service will be completed by 3/22/19	e ure of ator to for	
	In an interview on 2/2	0/19 at 4:14 PM Nurse # 4			10% audit of current residents transfers/discharges will be completed	by	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345113	B. WING			C 02/22/2019	
NAME OF PI	ROVIDER OR SUPPLIER	ı		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	401 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND F	REHABILITATION CENTER		G	OLDSBORO, NC 27534		
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 623	MAR (medication adr code status, a copy of progress notes when the hospital. In an interview on 2/2 Social Worker (SW # any notice or reason or family of resident, floor would notify the stated she emailed the the month to notify he During an interview of Administrator stated if complete a transfer/d list the reason a resid hospital. The Admini started at the facility a sure if staff were com 2. Resident #87 was facility on 5/31/17, wi Muscle Weakness (g and Hypertension. According to the control of the progression of the control of the control of the progression of the control of the control of the progression of the control of the control of the control of the progression of the control of the contr	end a copy of the residents' ministration record), their of their face sheet and the sending a resident out to ending a resident out to end for discharge to the resident because the nurse on the family by phone. The SW are Ombudsman at the end of er of facility discharges. In 2/21/2019 at 3:14 PM the expected staff to ischarge form, which would lent was going to the strator stated he had only a month ago and was not appleting the form. It is originally admitted to the th diagnoses including eneralized), Polyneuropathy coording to the most recent entata Set (MDS) dated 1/9/19,	F6	523	the Director of Nursing weekly x 8 week then monthly x 1 month utilizing the Be Hold/Transfer Discharge Audit Tools. The audit is to ensure the resident and/or resident representative received a writtenotification of the transfer/discharge to include the reason for the transfer/discharge before/upon hospitate transfer with documentation in the clinic record. The social workers will be retrained for any identified areas of concerns during the audit. The Directon Nursing will review the Bed Hold/Trans Discharge Audit Tools weekly x 8 week and then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Director of Nursing will forward the Bed Hold/Transfer Discharge Audit Tools to the Executive QA Committee monthly 3 months. The Executive QA Committee will review the Tools monthly x 3 month to determine trends and / or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	d This en I cal or of fer es, es sls y x ee es t	
		scharged to the hospital on o the facility on 2/7/19.					
	Resident #87 reveale	n 2/18/19 at 10:50 AM, d he did not get letter eason he was discharged to					
	Nurse # 11 stated she	n 2/20/19 at 2:41 PM, Staff e was an agency nurse and discharged to the hospital					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345113	B. WING _			C 02/22/2019	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	'	<u> </u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623	Continued From page	ge 13	F 6	23			
	she did not send an resident about the r discharged to the ho	dent's family by phone, but ything written to the family or eason the resident was ospital. on 2/21/19 at 8:30 AM, Staff					
	Nurse # 12 revealed the hospital for a un urinary tract infection was discharged to t	d Resident #87 was sent to inalysis because he had a n. She stated when a resident he hospital, she notified the t she did not send anything					
	•	or resident about the reason scharged to the hospital.					
	conducted with the #1 stated she did no for discharge to the because the nurse of family by phone. The	203 AM, an interview was Social Worker (SW #1). SW of send any notice or reason resident or family of resident, on the floor would notify the ne SW stated she emailed the end of the month to notify her s.					
	Administrator stated face sheet, medicat form which would lis going to the hospital policy. The Adminis	on 2/21/19 at 3:14 PM, the I he expected staff to send the ions and a transfer/discharge at the reason a resident was I and a copy of the bed hold trator stated he had only a month ago and was not mpleting the form.					
	facility on 2/7/18, wi Congestive Heart F Disease, Type 2 Dia and Chronic Atrial F	s originally admitted to the th diagnoses including ailure, End Stage Renal abetes without complications ibrillation. According to the rly Minimum Data Set (MDS)					

1, 7		IDENTIFICATION NITIMBED:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345113	B. WING		C 02/22/2019
	ROVIDER OR SUPPLIER CREEK NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	OZIZZZO13
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 623	dated 1/17/19, Resi intact. Resident #98 was d 12/18/18 and return The resident was al on 1/3/19 and return During an interview Resident #98 she di information from the was discharged to the During an interview Nurse # 11 stated she when a resident was she notified the resishe did not send an resident about the redischarged to the houring an interview Nurse # 12 revealed the hospital because not working. She stadischarged to the hop phone, but she did the family or resident was discharged to the hop phone, but she did not conducted with the #1 stated she did not for discharge to the because the nurse of family by phone. The resident was discharge to the because the nurse of family by phone. The resident was discharge to the because the nurse of family by phone. The resident was discharge to the because the nurse of family by phone. The resident was discharge to the because the nurse of family by phone. The resident was discharge to the because the nurse of family by phone. The resident was discharge to the because the nurse of family by phone.	dent #98's cognition was ischarged to the hospital on ed to the facility on 12/21/18. So discharged to the hospital ned to the facility on 1/6/19. on 2/18/19 at 3:45 PM, d not get any written a facility about the reason she ne hospital. on 2/20/19 at 2:41 PM, Staff ne was an agency nurse and a discharged to the hospital dent's family by phone, but yithing written to the family or eason the resident was ospital. on 2/21/19 at 8:30 AM, Staff I Resident #98 was sent to be her shunt (for dialysis) was atted when a resident was ospital, she notified the family id not send anything written to be about the reason the reged to the hospital. 03 AM, an interview was Social Worker (SW #1). SW of send any notice or reason resident or family of resident, on the floor would notify the ne SW stated she emailed the end of the month to notify her	F 62	23	

' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	` ′	COMPLETED	
		345113	B. WING _			C 02/22/2019	
NAME OF PROVIDER OR SUPPLIER WILLOW CREEK NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	I	02/22/2019	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 623	Administrator stated face sheet, medicatic form which would list going to the hospital policy. The Administr started at the facility sure if staff were conducted with Nurshad sent Resident #135 was 12/3/2014 with diagn gastrointestinal hemodisease, and hydrone Resident #135 was 12/3/2018 and re-administration and re-administrati	on 2/21/19 at 3:14 PM, the he expected staff to send the ons and a transfer/discharge the reason a resident was and a copy of the bed hold rator stated he had only a month ago and was not appleting the form. It is admitted to the facility on oses to include orrhage, chronic kidney ephrosis. It is charged to the hospital on mitted to the facility on arged to the hospital on dimitted to the facility on arged to the hospital on mitted to the facility on arged to the hospital on mitted to the facility on arged to the hospital on mitted to the facility on arged to the hospital on mitted to the facility on arged to the hospital on mitted to the facility on arged to the resident on mitted to the facility on the facility on the facility on the interviewed. #135's medical record to indication the resident's written notification for the nt's transfer to the hospital	F 6	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345113	B. WING				22/2019
	ROVIDER OR SUPPLIER CREEK NURSING AND R	EHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	IX (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 625 SS=C	conducted with the Soff #1 stated she did not for discharge to the rebecause the nurse or family by phone. The Ombudsman at the e of facility discharges. On 2/21/2019 at 3:14 conducted with the Adexpected staff to comform, which would list going to the hospital. had only started at the was not sure if staff w Notice of Bed Hold Poceros. 483.15(d)(1) Section 15(d)(1) Notice nursing facility transfet the resident goes on nursing facility must put the resident or reside specifies— (i) The duration of the any, during which the return and resume refacility; (ii) The reserve bed pplan, under § 447.40 (iii) The nursing facility bed-hold periods, which is the resident product.	3 AM, an interview was ocial Worker (SW #1). SW send any notice or reason esident or family of resident, in the floor would notify the e SW stated she emailed the end of the month to notify her. PM, an interview was diministrator, who stated he eplete a transfer/discharge at the reason a resident was. The Administrator stated he efacility a month ago and were completing the form. Olicy Before/Upon Trnsfr (2) bed-hold policy and return-before transfer. Before a ters a resident to a hospital or therapeutic leave, the provide written information to ent representative that e state bed-hold policy, if resident is permitted to sidence in the nursing sayment policy in the state of this chapter, if any; y's policies regarding ich must be consistent with its section, permitting a		625			3/22/19

PRINTED: 03/27/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345113 B. WIN				C 02/22/2019	
NAME OF PI	ROVIDER OR SUPPLIER		_ 	STREET ADDRESS, CITY, STATE, ZIP CODE		ZIZZIZO I J	
WILLOW (CDEEK MIIDSING AND E	DELIABII ITATION CENTED		2401 WAYNE MEMORIAL DRIVE			
VVILLOVV	CREEK NURSING AND P	REHABILITATION CENTER		GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 625	Continued From page	e 17	F 62	25			
	(iv) The information s of this section.	pecified in paragraph (e)(1)					
	the time of transfer of hospitalization or their facility must provide the resident representative specifies the duration described in paragraphis REQUIREMENT by: Based on record revinterviews the facility or resident represent transfer to the hospitalization of the findings included the findings included the finding facute Renath Hypertrophy, Anemia Dementia. A review of Resident Data Set (MDS) date having severely imparative and revaluation due to income and renal failure. He facility on 1/9/19.	rapeutic leave, a nursing of the resident and the ve written notice which of the bed-hold policy on (d)(1) of this section. This is not met as evidenced liew, family and staff failed to provide the resident active a bed hold policy when all was necessary for 4 of 4 te117, #87, #98 and #135) ization. It: It: It: It: It: It: It: It		F 625 Notice of Bed Hold Policy Before/Upon Transfer On 3/14/19 written notification of hold policy was provided to the R Resident Representative by the S Worker for Residents # 117, # 98 #135. 100% audit of current residents transfer/discharges x 30 days to i Resident # 117, # 98, # 87, #135 completed by the Social Worker tresident and/or resident represen received written notification of the hold policy when transferred to the hospital/discharge from the facility the audit, all areas of concern we addressed by the Social Worker to providing written notification of the on 3/14/19 by certified mail. On 2/21/19, an in-service was initivith all nurses and social workers Administrator regarding providing notification to the Resident/ Res	esident/ Social , #87, Include was o ensure Itative e bed he y. During re by e policy tiated s by the g written dent		
		n 2/21/2019 at 10:03 AM the #1 stated the business office		Representative for the Bed Hold I Before/Upon Hospital transfer wit	Policy		

Facility ID: 923020

PRINTED: 03/27/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G			
		345113	B. WING	B. WING		C 02/22/2019	
NAME OF P	ROVIDER OR SUPPLIER	J		STREET ADDRESS, CITY, STATE, ZIP CO	•		
				2401 WAYNE MEMORIAL DRIVE			
WILLOW CREEK NURSING AND REHABILITATION CENTER		REHABILITATION CENTER		GOLDSBORO, NC 27534			
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID	PROVIDER'S PLAN OF C		(X5) COMPLETION	
			PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	DATE	
F 625	Continued From page	e 18	F 62	25			
	was sending out the l spoke with the family	bed hold policy after they		documentation in the clinical newly hired staff nurses or s	ocial workers		
	In an interview on 2/2	21/2/19 at 3:14 PM the		will receive the in-service up orientation. The in-service w			
		ager (BOM) stated after a		completed by 3/22/19.	50		
		ged to the hospital, the					
		see if they wanted to hold a		10% audit of current residen			
		d she had no idea if the		transfers/discharges will be	•		
	nurses were sending the bed hold policy with a resident when they were discharged to the			the Director of Nursing week then monthly x 1 month utiliz			
	hospital.	rere discharged to the		Hold/Transfer Discharge Aug	-		
				audit is to ensure the resider			
	During an interview o	on 2/21/2019 at 3:14 PM the		resident representative rece			
	Administrator stated I	•		notification of the bed hold p	-		
		lischarge form and send a		before/upon hospital transfe			
	to the hospital.	a resident when discharged		documentation in the clinical nurse and/or the social work			
	-	originally admitted to the		retrained for any identified a			
		th diagnoses including		concerns during the audit. T			
		eneralized), Polyneuropathy		Nursing will review the Bed I			
		ccording to the most recent		Discharge Audit Tools weekl	•		
	•	Data Set (MDS) dated 1/9/19,		and then monthly x 1 month			
	Resident #87's cogni	tion was intact.		completion and to ensure all concern were addressed.	areas or		
	Resident #87 was dis	scharged to the hospital on		concern were addressed.			
		o the facility on 2/7/19.		The Director of Nursing will	I forward the		
				Bed Hold/Transfer Discharge	e Audit Tools		
		on 2/18/19 at 10:50 AM,		to the Executive QA Commit	•		
		ed he did not get a bed hold		3 months. The Executive QA			
	policy when he was c	discharged to the hospital.		will review the Tools monthly to determine trends and / or			
	During an interview o	on 2/20/19 at 2:41 PM, Staff		may need further interventio			
	_	e was an agency nurse and		place and to determine the r	•		
		discharged to the hospital		further and/or frequency of n			
		IR (do not resuscitate order)			5		
	demograhic sheet, a copy of the medication						
		(mar) to the hospital with					
		d she did not know about					
sending a bed hold po		olicy to the hospital with the					

Facility ID: 923020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345113	B. WING		C 02/22/2019	
NAME OF PROVIDER OR SUPPLIER WILLOW CREEK NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	1 02/22/2013	
(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 SHOUL CROSS-REFERENCED TO THE APPROFIDERICLENCY)	D BE COMPLETION	
F 625	and inform them. During an interview of Nurse #12 revealed F hospital for a urinalystract infection. She st discharged to the hoso of the medication adress face sheet, recent orders to send the resemergency room. She about sending the bewith the resident. Staresident was discharged business office would if they want a bed hold notify the family and the one that sent. On 2/21/2019 at 10:0 conducted with the Signary and the stated the business will be signary at the signary and the signary and the signary at the signary at the signary at the signary and the signary at t	n 2/21/19 at 8:30 AM, Staff Resident #87 was sent to the is because he had a urinary ated when a resident was spital, she would send a copy ninistration record (mar), ders or labs, and doctor's sident to the hospital e revealed she did not know d hold policy to the hospital ff Nurse #12 said if a ged to the hospital, the contact the family and ask d. She stated she would the doctor, if the doctor was the resident to the hospital. 3 AM, an interview was ocial Worker (SW #1). SW as office was sending out the	F 62			
	On 2/21/2/19 at 3:14 conducted with the B (BOM) who stated aff discharged to the hos to see if they wanted stated she had no ide the bed hold policy w were discharged to the On 2/21/2019 at 3:14 conducted with the Adexpected staff to com	spital, the family was called to hold a bed. The BOM as if the nurses were sending ith a resident when they be hospital. PM, an interview was dministrator, who stated he plete a transfer/discharge hold policy with a resident				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345113	B. WING			1	C / 22/2019
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		2401	EET ADDRESS, CITY, STATE, ZIP CODE I WAYNE MEMORIAL DRIVE LDSBORO, NC 27534	1 02/	22/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 625	facility on 2/7/18, with Congestive Heart Fa Disease, Type 2 Dial and Chronic Atrial Fil most recent Quarterl dated 1/17/19, Residintact. Resident #98 was dis 12/18/18 and returned The resident was alson 1/3/19 and returned During an interview of Resident #98 revealed behold policy when shospital. During an interview of Nurse #11 stated show when a resident was she would send a DN demograhic sheet, a administration record the resident. She sai sending a bed hold president. During an interview of Nurse #12 revealed in Nu	originally admitted to the hidiagnoses including illure, End Stage Renal poetes without complications orillation. According to the y Minimum Data Set (MDS) tent #98's cognition was scharged to the hospital on add to the facility on 12/21/18. To discharged to the hospital ed to the facility on 1/6/19. On 2/18/19 at 3:45 PM, and she did not get was she was discharged to the spital was an agency nurse and discharged to the hospital NR (do not resuscitate order) copy of the medication of (mar) to the hospital with dishe did not know about a solicy to the hospital with the solicy to the hospital with th	F	625	DEFICIENCY)		
	resident was dischar would send a copy o administration record orders or labs, and d	ged to the hospital, she					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345113	345113 B. WING			C 02/22/2019	
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	CODE	OLIZZIZO I S	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 625	hold policy to the hold policy to the hourse #12 said if a the hospital, the befamily and ask if the On 2/21/2019 at 1 conducted with the #1 stated the busing bed hold policy afton On 2/21/2/19 at 3: conducted with the (BOM) who stated discharged to the to see if they want stated she had no the bed hold policy were discharged to the to see if they want stated she had no the bed hold policy were discharged to the expected staff to conform and send a body when discharged to 4. Resident #135 12/3/2014 with diagastrointestinal hed disease, and hydromap (Passident #135 was 9/28/2018; and resident #135 was 9/28/2018; and resident #135 was 1/1/30/2018; and was 1/1/2019 and resident #130/2019.	not know about sending the bed nospital with the resident. Staff a resident was discharged to usiness office would contact the ney wanted a bed hold. 0:03 AM, an interview was a Social Worker (SW #1). SW ness office was sending out the er they spoke with the family. 14 PM, an interview was a Business Office Manager after a resident was hospital, the family was called ed to hold a bed. The BOM idea if the nurses were sending with a resident when they of the hospital. 14 PM, an interview was a Administrator, who stated he omplete a transfer/discharge ed hold policy with a resident to the hospital. was admitted to the facility on gnoses to include morrhage, chronic kidney	F	525			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	345113 B. WING		B. WING	ig.			C	
NAME OF P	ROVIDER OR SUPPLIER	040110		ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/	22/2019	
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER			01 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27534			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 625	Continued From page assessment dated 1/2		F	625				
	cognition was intact, v resident was unable t	with unclear speech. The obe interviewed.						
	conducted with Nurse a resident was discha demographics sheet, Administration Record	8 AM, an interview was 4 #2. Nurse #2 stated when rged to hospital she sent a a copy of the Medication d (MAR), a copy of the a copy of the Do Not						
	Resuscitate (DNR) for resident. The nurse soffice staff to notify the as a written copy of the staff to the s							
	conducted with the So #1 stated the busines	3 AM, an interview was ocial Worker (SW #1). SW s office was sending out the hey spoke with the family.						
	(BOM) who stated aft discharged to the hos to see if they wanted stated she had no ide	usiness Office Manager er a resident was pital, the family was called to hold a bed. The BOM a if the nurses were sending th a resident when they						
F 698 SS=D	conducted with the Adexpected staff to comform and send a bed when discharged to the Dialysis	PM, an interview was dministrator, who stated he plete a transfer/discharge hold policy with a resident ne hospital.	F	698			3/22/19	

PRINTED: 03/27/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					C 02/22/2019	
	NAME OF PROVIDER OR SUPPLIER WILLOW CREEK NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	1 02/22/2010	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 698	require dialysis recewith professional state comprehensive personal state	sure that residents who ive such services, consistent andards of practice, the con-centered care plan, and and preferences. T is not met as evidenced on, record review and staff failed to provide ongoing umentation with the for 1 of 1 resident reviewed d to document an esident's status, shunt site returning to the facility after 118). The findings included: admitted to the facility on agnosis of end stage renal Plan dated 1/18/19 noted the age renal disease and was at so due to hemodialysis. ednesday and Friday. Assess from dialysis treatment and of any significant changes. for bleeding and/or signs of mum Data Set (MDS) 1/23/19 revealed the resident chand required extensive to activities of daily living sistance with eating. The dent received dialysis while	F 69	F698 Dialysis After returning from Dialysis, residen 118 will receive an assessment of the resident s status, shunt site, and vit signs with documentation in the clinic record by the hall nurse by 3/22/19. communication tool will be sent with resident # 118 to dialysis by the hall by 3/22/19 to allow for communicatio between the facility and dialysis cent 100% audit of the progress notes for past 30 days will be completed by 3/2 by the Quality Improvement (QI) Nur all residents receiving dialysis to incli resident #118, to ensure that residen received an assessment of the reside status, shunt site, and vital signs upo return from dialysis. Any identified ar of concerns will be addressed during audit by the QI Nurse. The Director of Nursing will devised a communication by 3/22/19 for the communication between the facility and the dialysis center. 100% in-service was initiated on 2/2/2 by the Director of Nursing for all nurs include nurse #1 regarding assessment the resident status, shunt site, and signs post dialysis with documentation	e al cal cal A nurse n er. the 22/19 se for ude ts ent s en eas the of n tool	

Facility ID: 923020

PRINTED: 03/27/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMF	SURVEY PLETED
			7 501251	_		,	С
		345113	B. WING				/22/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	401 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND R	REHABILITATION CENTER		G	GOLDSBORO, NC 27534		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 698	Continued From page	e 24	F	698			
		al signs were documented in			the clinical record; the dialysis		
		in the vital signs tab of the			communication tool is to be sent with		
		was admitted to the hospital			each resident to dialysis to ensure		
		ed for osteomyelitis and was			effective communication between the		
	I .	ility on 2/6/19. There was a			facility and dialysis center; and review	the	
		nent documented on 2/20/19			communication tool upon residents retu		
	, .	al signs documented. There			from dialysis for any changes. The		
	I .	entation of a post dialysis			in-service will be completed by 3/22/19		
		lialysis vital signs found in			All newly hired nurses will receive the		
	I .	Review of the Medication			in-service upon hire in orientation by th	е	
	Administration Recor	d for January and February			Staff Facilitator.		
	of 2019 revealed no p	oost dialysis assessment or					
	vital signs.				10 % audit of all residents to include		
					resident # 118 receiving dialysis treatm		
		M Resident #118 stated			will be reviewed by the QI Nurse weekl	-	
	during a resident inte				8 weeks then monthly x 1 month utilizing		
	_	the nurse would come in			the dialysis review tool. This audit is to		
		The Resident stated she			ensure an assessment of the resident	S	
	_	ding from her shunt after			status, shunt site, and vital signs post		
	dialysis since admiss	ion to the facility.			dialysis is documented in the clinical		
					record and the dialysis communication		
	On 2/20/19 at 1:00 Pl				tool was completed and sent to dialysis		
	I .	e #1 who stated dialysis			Any identified areas of concerns will be		
		munication book that is sent			addressed during the audit by retraining	-	
	with the resident to di	-			the nurse by the QI Nurse. The Directo)ľ	
		that listed vital signs and			of Nursing will review and initial the		
	other pertinent inform	ation for the dialysis unit.			dialysis communication tool weekly x 8 weeks then monthly x 1 month for		
	On 2/20/10 at 4:06 D	M Nurse #1 stated in an			completion and to ensure all areas of		
		eturn from dialysis the nurses			concern were address.		
	1	shunt site for bruit and thrill			Sonson were address.		
		is no bleeding from the			The Director of Nursing will forward the	e	
	I .	signs and check to make			Dialysis Review Tools to the Executive		
	sure there have been	•			Committee monthly x 3 months. The	ω , ι	
		us. The Nurse stated this			Executive QA Committee will review th	e	
		e documented under the			Tools monthly x 3 months to determine		
		gress notes. Nurse #1 was			trends and / or issues that may need		
	observed to review th	_			further interventions put into place and	to	
	I .	ated the assessment was			determine the need for further and / or		

Facility ID: 923020

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345113	B. WING _				C 22/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 02/	22/2013
WILLOW	CREEK NURSING AND	REHABILITATION CENTER			01 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27534		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 698	Continued From pag	je 25	F 6	98			
	not being consistent	ly documented.			frequency of monitoring.		
	The DON stated the with the resident to oupon return from diathe sheet for any net dialysis. Review of a revealed a space for prior to dialysis along 24-48 hours. There is of the dialysis site at weights and concern. On 2/21/19 at 12:25 conducted with the fafter a request was a communication sheet Nurse Consultant standard the communication of the communication of the prior of the dialysis regarding the consultant standard the communication of the prior of the consultant standard the communication of the prior of the consultant standard the communication of the consultant standard the communication of the communication book for Resident # not been set up (the sheets). The DON fut the staff to look at the communication book for Resident book for Resident the communication book for Resident book for Resident the communication book for Resident book for Resident the communication to the communication book for Resident the communication t	PM an interview was Director of Nursing (DON). communication sheet goes dialysis with the resident and lysis, the nurse would look at worders or concerns during a blank communication sheet or documentation of vital signs gray with any changes in the last was a space for assessment and a place for wet and dry as/comments/orders. PM an interview was acility's Nurse Consultant made to review the dialysis sets for Resident #118. The lated this resident did not on book prepared and the mmunicating with dialysis by an unication with dialysis wrogress notes was dated when the facility called the insertion of an access line. AM the Director of Nursing anterview the communication with the communication with the communication and the were no communication and the resident returned communication from the					
F 761 SS=E	dialysis unit. Label/Store Drugs a CFR(s): 483.45(g)(h		F 7	61			3/22/19
,, <u> </u>	, , , , , , , , , , , , , , , , , , , ,						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		OATE SURVEY OMPLETED
		345113	B. WING _			C 02/22/2019
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	E	02/22/2013
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 761	Continued From pag	e 26	F 7	61		
	Drugs and biological labeled in accordance professional principle appropriate accesso					
	§483.45(h) Storage	of Drugs and Biologicals				
	Federal laws, the factoriologicals in locked	ordance with State and compartments under proper and permit only authorized coess to the keys.				
	locked, permanently storage of controlled the Comprehensive Control Act of 1976 a abuse, except when package drug distrib quantity stored is mit be readily detected.	acility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can				
	review of manufactural failed to refrigerate in failed to date medication refrigerate carts observed. The a medication refrigerate temperature for medication refrigerate medication refrigerate.	on, staff interviews and rer's specifications the facility nedications as required and ations when opened for 2 of 2 fors and 3 of 5 medication facility also failed to maintain rator at the specified ication storage for 1 of 2 fors. The findings included:		F 761 Label/Store Drugs and (1) The 2 open vials of Purific Derivative (PPD) Solution that opened and not dated, was depended per policy by the hat 2/21/19. The Levemir Insuling hall medication cart was discarged per policy by the hat 2/21/19. The Xalatan Eye Drugon hall medication cart was and reordered per policy by the hat 2/21/19.	ed Protein It were iscarded and all nurse on on the 400 arded and all nurse on ops on the discarded	

OLIVILIV	O T OIT MEDIO TILE G	MEDIO/ ND CEITTIOEC				<u> </u>	2. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	.,		(С
		345113	B. WING			02/	22/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WILLOW	CREEK NURSING AND F	REHABILITATION CENTER			401 WAYNE MEMORIAL DRIVE		
				G	OLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					·		
F 761	Continued From page	e 27	F	761			
	used in the diagnosis			, , ,	on 2/21/19. (2) All medications were		
		age insert for PPD says a			removed from the 100/300 medication		
		peen entered and in use for			room refrigerator and discarded on		
		scarded. On 2/21/19 at 2:01			2/21/19 by the hall nurse. Replacemen	t	
	_	f the medication refrigerator			medications were ordered per policy or		
	I .	tions for the 900, 1000, and			2/22/19 by the hall nurse. The 100/300		
		with Nurse #8. There were			medication room refrigerator temperatu		
		PPD and approximately one			gauge was adjusted to the proper		
	_	ation remained in the bottle.			temperature setting by maintenance or	1	
	•	n the bottles to show when			2/22/19.		
	the bottles were oper	ned. During the observation,					
	I -	here was not a date on the			(1) 100% audit will be completed by		
	bottles and stated the	e vials of PPD were good for			03/22/19 by the RN Supervisor of all		
	30 days after they we				medications inside the medication carts	3	
	On 2/22/10 at 0:24 A	M the Director of Nursing			and medication rooms to include 100,	ıro	
	I .	M the Director of Nursing terview she expected the			200, 300, 400 hall. This audit is to ensual medications to include PPD,	ii C	
	nurses to date medic				biologicals, and Xalatan, were dated w	hon	
	marses to date medic	ations when opened.			opened and stored per manufacture	ilon	
	2. Levemir Insulin is a	a long acting insulin used to			specifications. Any area of concern wa	S	
	treat diabetes mellitus	s. The manufacturer's			addressed during the audit by the RN		
	package insert advise	ed to store unopened vials in			Supervisor by discarding and reorderin		
		o dispose of any vial that had			medications per policy. (2) 100% audit	will	
	1	han 42 days. On 2/21/19 at			be completed by 3/22/19 by the RN		
		ion of the medication cart on			Supervisor of all medication refrigerato		
	the 400 Hall was mad				temperature to ensure that temperature		
		ed vial of Levemir insulin. The			are maintained at a range of 36-46 F.	-	
	label on the container				area of concern was addressed during		
		ned." It was also noted on the			audit by the RN Supervisor by discardi	-	
		after opened." The vial of			and reordering medications per policy	ario	
	insulin was not dated				adjusting the refrigerator temperature		
	removed from the ref	-			gauge.		
		2 stated the resident had			100% in conting was initiated on 2/24/4	0	
		nir insulin on the medication			100% in service was initiated on 2/21/1		
	1	ed vial was delivered by the Xalatan eye drops are used			by the Director of Nursing with all nurse to include nurse # 8, # 2, # 9 and	50	
	, .	e in the eye or glaucoma.			medication aides regarding checking		
		ackage insert for Xalatan			medication aides regarding checking medication carts and medication room	e	
		store unopened Xalatan eye			daily to ensure that PPD, biologicals, a		
	Sys arops advised to	otoro arroportou Adiatair Cyc			same to official trial in D, biologicals, a		I.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
						(С
		345113	B. WING _			02/	22/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
\A/II I O\A/	CDEEK MUDGING ANI	D DELIABILITATION CENTED		2	401 WAYNE MEMORIAL DRIVE		
WILLOW	CREEN NURSING ANI	D REHABILITATION CENTER		G	GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From pa	age 28	F 7	761			
	drops in the refrige	erator until opened and once			Xalatan are dated and stored per		
		oom temperature for up to 6			manufacture specifications; ensuring		
		e also 2 unopened bottles of			medication room refrigerators maintain	i	
		on the medication cart that			the appropriate temperature range of		
		show when the bottles were			36-46F; and the process to follow when	า	
		refrigerator. One bottle was			refrigerated temperatures are out of ra		
		pharmacy on 2/13/19 and the			to include adjustment of the refrigerato	r	
	other bottle on 2/20	0/19.			temperature gauge and notification of		
					maintenance. All newly hired nurses a	and	
		AM the Director of Nursing			medication aides will receive the in		
	stated in an intervi	ew she expected the nurses to			service during orientation by the Staff		
		see how the medication was to			Facilitator. This in-service will be		
	-	ected the medications to be			completed by 3/22/19.		
	dated when opene	d.			4000/ 5 11 11 11 11 11 11		
					100 % of all medication carts, medicati		
		34 PM an observation of the			rooms and medication room refrigerato		
	_	rator used to store medications			temperatures to include medication cal		
		e 100 and 300 Halls was made			on the 100, 200, 300, and 400 halls an		
		emperature chart was posted			the 100/300 medication room refrigera		
		refrigerator that listed 3 ire ranges one of which was			will be monitored by the RN Supervisor using a Medication/Temperature QI To		
		Room Refrigerator and noted			weekly x 8 weeks then monthly x 1 mo		
	, ,	nould be 36-46 degrees			This audit is to ensure that all medicati		
		aily temperatures recorded on			inside the medication carts and	JIIS	
		orded as follows: 2/20/19 AM			medications rooms to include PPD,		
		PM temp 34 degrees. 2/21/19			biologicals, and Xalatan, were dated w	hen	
		grees and PM Temp 34			opened and stored per manufacture		
		AM Temp 34 degrees. The			specifications. This audit is also to ens	ure	
	•	et listed Corrective Action and			that medication room refrigerator		
	noted if the temper	rature was out of range to notify			temperatures are being checked,		
		epartment and the manager. It			maintained between 36-46 degrees an	d	
		retake the temperature in one			adjusted when out of range with		
	hour. There were r	multiple insulin vials and			notification to maintenance. The nurse	or	
	Purified Protein De	erivative (PPD) stored in the			medication aide will be immediately		
	refrigerator. The m	anufacturer's package insert			re-trained during the audit and medical	ion	
	said to store insulir	n at 36 to 46 degrees			discarded and reordered per policy by	the	
	Fahrenheit and the	e package insert for PPD said			RN Supervisor for any identified areas	of	
	to store the medica	ation at 35 to 46 degrees			concern. The Director of Nursing will		
	Fahrenheit.				review and initial the		

PRINTED: 03/27/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345113	B. WING _				C / 22/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	22/2019
					01 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER			OLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	stated the unit managat the temps for the merigerators listed on posted on the front of to 42 degrees Fahrer refrigerator temperate degrees Fahrenheit. On 2/22/19 at 9:24 Al (DON) stated in an innight supervisor or the refrigerator temperate parameters were supmaintenance if the menot in the range required. 4. Purified Protein Deused in the diagnosis manufacturer's packatial of PPD that has been also as a superfigerator used to stresidents on the 100 #9. There was one visionened and was appfull. There was not a when the bottle had been confirmed there was stated the medication it was opened. On 2/22/19 at 9:24 Al stated in an interview medications to be dated.	AM the Director of Nursing per told her she was looking ourishment/patient the temperature chart the refrigerator that read 31 theit and not the medication are listed as 36 to 46. Which the Director of Nursing terview she expected the enight nurse to check the are and to know what the posed to be and contact edication refrigerator was red to store medications. Arivative (PPD) is a skin test of tuberculosis. The age insert for PPD says a peen entered and in use for excarded. On 2/21/19 at 2:34 as made of the medication for and 300 Halls with Nurse all of PPD that had been roximately three quarters date on the vial to show peen opened. Nurse #9 not a date on the vial and a was good for 30 days after. Which the Director of Nursing she expected the	F7	761	Medication/Temperature QI Tool for completion and to ensure all areas of concerns were addressed weekly X 8 weeks then monthly X 1 month. The Director of Nursing will forward the results of the Medication/Temperature Tool to the Executive Quality Improvem Committee monthly x 3 months to determine trends and / or issues that mneed further interventions put into place and to determine the need for further at / or frequency of monitoring.	QI nent nay e	

Facility ID: 923020

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345113	B. WING _				C 22/2019
	ROVIDER OR SUPPLIER CREEK NURSING AND F	EHABILITATION CENTER		240	REET ADDRESS, CITY, STATE, ZIP CODE D1 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	unopened Xalatan ey until opened and once temperature for up to 2:42 PM an observation medication cart used Hall. There was one deeye drops on the cart pharmacy on 2/19/19 read: "Refrigerate unit a label on the contain weeks after opening." On 2/22/19 at 9:24 Al stated in an interview read the labels to see be stored and expect dated when opened. QAPI/QAA Improvem CFR(s): 483.75(g)(2) §483.75(g) Quality as §483.75(g)(2) The quassurance committee (ii) Develop and impleaction to correct identity REQUIREMENT by: Based on record revision facility Quality Assess Committee (QAA) fail procedures and monic committee put in place for a deficiency that ce 6/1/2018 and was sufficiency and monic committee put in place for a deficiency that ce 6/1/2018 and was sufficiency.	r glaucoma. The ge insert advised to store e drops in the refrigerator e opened, store at room 6 weeks. On 2/21/19 at on was made of the for residents on the 200 unopened bottle of Xalatan that was dispensed by the . The label on the container iil opened." There was also er that read: "Expires 6 of the how the medication was to ed the medications to be ent Activities (iii) seessment and assurance. ality assessment and must: ement appropriate plans of tified quality deficiencies; it is not met as evidenced ew and staff interviews, the ement and Assurance ed to maintain implemented tor interventions that the e in June 2018. This was		867	F867 QAPI/QAA Improvement Activiting The Administrator, Director of Nursing (DON) Quality Improvement (QI Nurse) and Registered Nurse Supervisors (RN Supervisor), will be educated by the corporate consultant on the QA process to include implementation of Action Pla Monitoring Tools and the Evaluation of), I s, ns,	3/22/19

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345113	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	0.01.0	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		2/22/2019
TVAIVIL OF T	TOVIDER OR OUT FIER				_	
WILLOW (CREEK NURSING AND F	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 867	Continued From page	e 31	F 8	67		
	documentation. The facility during two fed a pattern of the facilit effective Quality Assu	_		QA process, including identify that warrant development and system to monitor the correct implement changes when the outcome is not achieved.	d establish a ions and expected	
	The findings included This tag is cross refe			The Administrator will comple audit of previous citation action within the past year to include	on plans	
	review and staff interprovide ongoing comwith the hemodialysis reviewed for dialysis assessment of the reand vital signs upon dialysis (Resident #1). During the facility's presurvey, they failed to	rior June 2018 recertification monitor a dialysis residents led to provide nursing		This audit is to ensure that the committee has maintained an interventions that were put int 3/22/19. Action plans will be rupdated and presented to the Committee by the Administrat 3/22/19 for any identified concerns and current citations dialysis will be taken to the Quality Assurance committee by the Aguality Assurance committee the data and determine if plar	ad monitored to place by revised and a QA tor by cerns. d systemic s to include uality Administrator s. The will review	
	treatments and failed communication documendialysis center of for dialysis (Resident On 2/22/2019 at 10:2 conducted with the Administrator stated in-serviced for checking and the Medication Adocumenting the assignificant dialysis progress note the he was unable to	to provide ongoing mentation with the for 1 of 1 residents reviewed #72). 1 AM, an interview was dministrator. The the staff had been ing the dialysis access site dministration Record, essment, and completing the es. The Administrator stated find the end results of the are the documentation was		corrections are being followed in plans of action are required outcomes, if further staff educ required, and if increased mo required. Minutes of the Quali Assurance Committee will be monthly at each meeting by the Records Manager. The results of the Monthly Que Assurance meeting minutes we presented by the Administrate DON to the Executive Commit Quarterly x 2 for review and the identification of trends, developments as indicated to describe the plans as indicated to describe the requirements.	d, if changes I to improve cation is nitoring is ity documented he Medical uality vill be or and/or ittee he opment of	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ONSTRUCTION	(X3) DATE COMF	SURVEY
		345113	B. WING _				C / 22/2019
NAME OF PI	ROVIDER OR SUPPLIER		I	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 02/	ZZ/ZO13
WILLOW	CDEEK MIIDSING AND E	REHABILITATION CENTER		240	1 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND P	REHABILITATION CENTER		GO	LDSBORO, 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)		(X5) COMPLETION DATE
F 867	Continued From page	e 32	F 8		need and/or frequency of continued monitoring.		
F 883 SS=D	Influenza and Pneum CFR(s): 483.80(d)(1)	ococcal Immunizations (2)	F 8		mornioning.		3/22/19
	policies and procedur (i) Before offering the each resident or the receives education repotential side effects (ii) Each resident is o immunization Octobe annually, unless the icontraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv) The resident's me documentation that ir following: (A) That the resident was provided education and potential side effirmunization; and (B) That the resident immunization or did rimmunization or did rimmunization due to refusal. §483.80(d)(2) Pneummust develop policies that- (i) Before offering the immunization, each refusion in the resident refusion of the resident control of the refusal of the resident immunization due to refusal.	za. The facility must develop res to ensure that- influenza immunization, resident's representative regarding the benefits and of the immunization; ffered an influenza in 1 through March 31 immunization is medically resident has already been resident has already been resident's representative refuse immunization; and dical record includes redicates, at a minimum, the resident's representative regarding the benefits rects of influenza reither received the influenza reither received the influenza redical contraindications or resident's representative receive the influenza rects of influenza rects					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		TE SURVEY MPLETED
		345113	B. WING _			C 2/22/2019
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534	•	2/22/2013
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 883	immunization, unless medically contraindic already been immunition (iii) The resident or the has the opportunity to (iv) The resident's medocumentation that in following: (A) That the resident was provided educat and potential side effimmunization; and (B) That the resident pneumococcal immunication or resident pneumococcal immunication or resident pneumococcal immunication or resident years on record revised on record revised in the facility failed to docure ducation regarding resident who refused (Resident #27) and for received the influenz The findings included The facility's policy tirrevised on 10/18/17 influenza vaccine, rerepresentatives will be regarding the benefit of these immunization medical record."	If side effects of the offered a pneumococcal is the immunization is stated or the resident has sized; he resident's representative or refuse immunization; and edical record includes indicates, at a minimum, the or resident's representative ion regarding the benefits fects of pneumococcal either received the inization or did not receive inmunization due to medical efusal. If is not met as evidenced riew and staff interviews the ment the provision of risks/benefits for 1 of 1 If the influenza vaccine or 1 of 4 residents who a vaccine (Resident #83).	F8	F 883: Influenza and Pneume Immunizations Resident # 27 was reoffered to vaccination with provision of exprovided regarding risk/benefinfluenza vaccination prior to decision with documentation record by 3/22/19 by the Qual Improvement (QI) Nurse. Resident # 83 will be educate Nurse on the influenza vaccin provision of education regard risk/benefits on the influenza with documentation in the clir by 3/22/19. Provisional educate garding risk/benefits will conprovided prior to the decision decline the vaccination.	the influenza education its on the making a in the clinical lity ed by the QI nation with ing vaccination nical record ation ntinue to be	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			750.25.			(2
		345113	B. WING			l	22/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MILL 014/	ODEEK NUDOWO AND E	NELLA DIL ITATIONI GENTED		24	401 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND F	REHABILITATION CENTER		G	OLDSBORO, NC 27534		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 883	Continued From page	e 34	F:	883			
	failure, diabetes melli	itus, cerebrovascular					
	accident (stroke) and	chronic obstructive			100% audit of all resident medical reco	rds	
	pulmonary failure (C0	OPD) with respiratory failure.			to include residents # 27 and # 83 were	•	
					reviewed to determine if the influenza		
		mum Data Set (MDS)			vaccination had been administered or		
		rly) dated 11/22/18 revealed			declined with provisional education on		
	Resident #27 was co	gnitively intact.			risk/benefits provided with documentat	on	
		1.1. (in the clinical record on 3/15/19 by the		
	· ·	date form dated 12/6/18			Director of Nursing. Education will be		
	noted Resident #27 r	ted a space to indicate the			provided to any resident or resident	_	
		led to the resident/family.			representative that has not received the education with documentation in the	5	
	_ ·	ation on the form to show the			clinical record by 3/22/19.		
		d the risks and benefits of			Girliodi record by 0/22/10.		
	receiving/refusing the				100% in-service for all nurses was		
	J J				completed by 3/22/19 regarding provid	ing	
	On 2/22/19 at 9:16 A	M the Director of Nursing			education and documentation in the	J	
		terview the social worker			clinical record of provisional education		
	obtained the permiss	ion for the influenza			regarding risk/benefits on the influenza		
	vaccines and docume	ented in the clinical record			vaccine to the resident and/or resident		
	whether the resident	consented or refused the			representative prior to the decision to		
	vaccine.				receive or decline the vaccination.		
	On 2/22/19 at 10:02	AM Social Worker #1 and			10% of all residents to include resident	#	
	Social Worker #2 wei	re interviewed. Social			27 and #83 will be reviewed by the (C	l)	
	Worker #1 stated the	y got verbal consents from			Nurse weekly for 8 weeks and monthly	/ X	
		sidents for the influenza			1 month utilizing the influenza vaccine		
	vaccine but did not pi	rovide the education at that			audit tool. This audit is to ensure that a		
	time.				residents receive provisional education		
	0.00040.44.55	***			regarding risk/benefits of the influenza		
		AM a separate interview with			vaccine prior to the decision to receive	or	
		e social workers did not			decline the vaccination. Any identified areas of concerns will be addressed		
	·	n for the influenza vaccine vent in to give the injection			during the audit by retraining the nurse	hv	
		provide the education piece			the Quality Improvement Nurse. The	IJy	
	prior to giving the vac				Director of Nursing will review and initia	al	
	phonic giving the vac				the influenza vaccine audit tool weekly		
					weeks then monthly x 1 month for	•	
	2. Resident #83 was	admitted to the facility on			completion and to ensure all areas of		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345113	B. WING				C
NAME OF PE	ROVIDER OR SUPPLIER	0.01.0	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/	22/2019
TO THE OT THE	TO VIDENCO IN COST I EIEN				01 WAYNE MEMORIAL DRIVE		
WILLOW	CREEK NURSING AND R	EHABILITATION CENTER			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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 883	Continued From page	÷ 35	F8	83			
	5/19/14 and had a dia	agnosis of arthritis,			concern were address.		
	hypertension and a hi	istory of pneumonia.					
	The Quarterly Minimu	um Data Sat (MDS)			The Director of Nursing will forward the Influenza vaccine audit tool to the	9	
	The Quarterly Minimu	0/9/18 revealed Resident			Executive QA Committee monthly x 3		
	#83 was cognitively in				months. The Executive QA Committee	will	
					review the Tools monthly x 3 months to		
	•	late form dated 10/19/18			determine trends and / or issues that n	•	
		onsented to receive the ere was a space to indicate			need further interventions put into plac and to determine the need for further a		
	the provision of educa				/ or frequency of monitoring.	iiiu	
		was no information on the					
		dent was provided the risks ing the influenza vaccine.					
	(DON) stated in an in obtained the permissi vaccines and docume	M the Director of Nursing terview the social worker on for the influenza ented in the clinical record consented or refused the					
	Social Worker #2 wer Worker #1 stated they alert and oriented res	AM Social Worker #1 and re interviewed. Social y got verbal consents from idents for the Influenza rovide the education at the					
	the DON revealed the provide the education but when the nurse w	AM a separate interview with e social workers did not for the influenza vaccine tent in to give the injection provide the education piece scine.					