SEP 24 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING _____ B. WING _____	C 08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, and record review the facility failed to invite residents/family members to the quarterly care plan meetings for 1 of 3 residents (Resident #198) whose families were interviewed during stage I of the survey. Findings include: Resident #198 was admitted to the facility on 11/16/10 and readmitted on 07/16/12. The resident's documented diagnoses included dementia, diabetes, and hypertension.	F 280	Willow Creek acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Willow Creek's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Willow Creek reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other Administrative or legal proceeding.	9/25/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bonnie Lord	Administrator	9/20/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	Continued From page 1 Record review revealed a 02/22/12 Quarterly Minimum Data Set (MDS) assessment was completed for Resident #198. Review of electronic care plan documentation revealed a 03/06/12 care plan meeting was held with the resident's family in conjunction with the 02/22/12 assessment. Record review revealed a Quarterly MDS was completed for Resident #198 on 05/17/12, and an Annual MDS was completed for the resident on 07/27/12. Review of electronic care plan documentation revealed no care plan meetings had been scheduled in association with the 05/17/12 or the 07/27/12 MDS assessments. At 11:37 AM on 08/27/12 a family member of Resident #198 stated the resident was unable to attend care plan meetings, but the family liked to participate in them to share concerns and to be updated on the resident's care. However, this family member stated a care plan conference was not held for Resident #198 in the past five or six months. According to the family member, the family wanted to discuss issues regarding blood sugar and blood pressure control, and these care plan conferences allowed such an opportunity. At 4:33 PM on 08/28/12 social worker (SW) #1 stated a care plan meeting had not been held for Resident #198 since 03/06/12 because the facility had new MDS staff, and the facility was trying to "bring them up to speed." She reported normally the MDS staff generated a summary of what was to be discussed during the care plan meetings,	F 280	A care plan meeting was held with the Responsible Party for resident #198 on 9/4/12. An audit of 100% of active residents using a current resident census was completed on 9/7/12 by the social workers. Notifications of care plan meetings were mailed by the social workers by 9/20/12 to resident or responsible party as deemed necessary by results of audit. The social workers and other care plan team members were re-educated by the Administrator/Staff Facilitator by 9/14/12 related to the process for ensuring residents and Responsible Parties are notified of care plan meetings and also on the process and rationale for holding care plan meetings.	9/25/12

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F 280	Continued From page 2 and set a tentative date for the meetings. The SW commented it was the responsibility of social services to contact the families and set a final date convenient for them to attend care plan meetings. However, the SW explained during the training of new MDS staff the summary of topics to be discussed and the tentative care plan meeting dates were not being generated by the MDS department. At 2:55 PM on 08/29/12 the MDS Coordinator stated care plan meetings were held after all Admission, Quarterly, Annual, and Significant Change MDS assessment were completed. She reported she was unaware of any systems problem with care plan meetings being held on a timely basis. However, she commented the facility was short MDS staff last month so the SW department was asked to review care plan areas which were triggered by MDS assessments, and to set up the care plan conferences. According to the coordinator, the SW staff was told if they had any problems, to come to the MDS department for assistance. The MDS Coordinator stated she was unaware of the SW staff approaching the MDS department for assistance regarding Resident #198. At 8:47 AM on 08/30/12 the director of nursing (DON) stated care plan meetings were held quarterly, and more often if residents/families had special requests to discuss problems with care. She reported she was unaware of any problems with the facility's system of the MDS staff generating areas of concern that triggered during assessments, the MDS staff setting a tentative date for care plan meetings, and the SW department working with residents/families to set	F 280	A Care Plan QI Log for Medicaid and the Medicare Assessment Schedulers will be used by the social workers as a guide for notification of residents and responsible parties of scheduled care plan meetings. The Administrator will be using the same tools weekly x 8 weeks, then monthly x 1 to ensure residents and responsible parties are notified of scheduled care plan meetings as noted in the residents Medical Record. The audit tools will be initialed and dated to designate audit completion. The results of the audit will be reviewed by the Quality Improvement Nurse weekly x 8 then monthly x 1. The results will be compiled and forwarded to the Quality Improvement Committee for monthly review for identification of trends, development of action plans and to determine the need and / or frequency of continued monitoring.	9/25/12

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F 280	Continued From page 3 up the final date for these care plan conferences.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to follow standing orders for addressing low blood sugar levels, and failed to recheck blood sugar levels in a timely manner after interventions were put in place for 1 of 8 sampled residents (Resident #198) who were diabetic. Findings include: Standing orders for Resident #108 documented, "Hypoglycemia: 1. For blood sugar levels of 60 or less, give OJ (orange juice) with packets of sugar and notify MD (physician)...." Resident #198 was admitted to the facility on 11/16/10 and readmitted on 07/16/12. The resident's documented diagnoses included diabetes and dementia. The resident's 05/17/12 Quarterly Minimum Data Set (MDS) documented she had severely impaired cognition and required extensive assistance from a staff member and was totally dependent on staff for her activities of daily living	F 309	Diabetic Residents to include resident # 198 with hypoglycemic episodes are having timely reassessment of blood sugar levels and proper implementation of standing orders for hypoglycemia as indicated by blood sugar levels and clinical documentation. Resident # 198 has had no documented episodes of hypoglycemia since 09-12-2012. All diabetic residents were audited for hypoglycemia episodes and implementation of the standing orders with timely reassessment back to 09-01-2012. The Staff Facilitator in-serviced all nurses and medication aides on facility standing orders fro hypoglycemia and timely reassessment of blood sugar beginning 09-04-2012 and completed on 09-20-2012.	9/25/12

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F 309	Continued From page 4 (ADLs). A 07/17/12 physician's order documented Resident #198 was to have her blood sugar checked four times a day (QID). At this same time the resident was receiving 20 units of Lantus insulin each morning and 500 milligrams (mg) of Glucophage/Metformin twice daily. Review of the resident's medication administration record (MAR) revealed Resident #198's blood sugar was 41 at 11:30 AM on 07/22/12. Review of the facility's grievance log revealed on 07/23/12 a family member of Resident #198 registered a complaint alleging that the nurse took the resident's blood sugar, which was 41, at 11:15 AM on 07/22/12, but did not return with orange juice and sugar to give the resident until 11:40 AM. The resident services liaison documented the grievance was resolved on 07/30/12 with one-on-one in-servicing provided to the nurse who was accused of untimely treatment of a low blood sugar. At 11:37 AM on 08/27/12 a family member of Resident #198 stated that on 08/24/12 around 3:00 PM the resident's blood sugar dropped to 41 again. This time the family member stated the resident was given artificial sweetener mixed in orange juice, and it was a long time before staff rechecked her blood sugar. At 10:50 AM on 08/29/12 a nursing assistant (NA) #2, who cared for Resident #198 on first shift, stated she was asked by a nurse to help bring the resident's low blood sugar up in the last couple of	F 309	New nurses and medication aides will receive education related to standing orders for hypoglycemia and timely reassessment of blood sugar during orientation to the facility by the Staff Facilitator. The administrative nurses to include the nursing supervisors, staff facilitator and quality improvement nurses will conduct audits, to include for resident #198, of hypoglycemic episodes and timely reassessment to include interventions provided to ensure that the facility standing order was followed and that reassessment was timely.	9/25/12

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F 309	Continued From page 5 weeks. The NA reported she was unsure how low the resident's blood sugar was, but she provided her with orange juice and a cookie. She also commented in the past she had stirred artificial sweetener with orange juice to give residents with low blood sugar. At 3:13 PM on 08/29/12 NA #4, who cared for Resident #198 on second shift, stated the nurses checked blood sugars, but she sometimes was asked to help provide interventions for low blood sugars. She reported she usually provided residents in this situation with orange juice and sugar-free cookies. At 3:25 PM on 08/29/12 medication aide (MA) #1 stated when she reported to her cart shortly after 3:00 PM on 08/24/12 Resident #198's family approached her about the resident possibly having low blood sugar. The MA reported the resident was more lethargic and confused than usual. She commented the resident's blood sugar was 41 when she took it, and she immediately provided the resident with two packets of artificial sweetener mixed with orange juice. According to the MA, she allowed the resident to receive her supper tray and then rechecked her blood sugar level for the first time shortly after 4:30 PM. MA #1 reported this was her first low blood sugar since becoming a MA about five months ago. The MA stated when she rechecked the resident's blood sugar shortly after 4:30 PM, it was above 60 but below 100. (Review of the MAR revealed the resident's blood sugar was 90 when rechecked). At 4:15 PM on 08/29/12 the director of nursing (DON) stated unless there was a specific MD	F 309	A QI tool will be completed daily for fourteen days, then five times per week for two weeks, then three times per week for two weeks, then one time per week for two weeks. Any concerns identified will be addressed by the administrative nurse at the time of the audit with follow up to the concern documented on the QI audit tool. Results of the audits will be reviewed and addressed weekly by the Director of Nursing or designee. The results will be compiled by the Quality Improvement committee for monthly review for identification of trends, development of action plans and to determine the need and/or frequency of continuing QI monitoring	9/25/12

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F 309	Continued From page 6 order, the routine standing order for hypoglycemia should be followed when a resident's blood sugar dropped below 60. (Record review revealed there were no specific orders regarding Resident #198's low blood sugar on 07/22/12 or 08/24/12). The DON reported she would expect no more than an hour to elapse before resident blood sugars were rechecked after providing orange juice and sugar. She commented giving orange juice and artificial sweetener and orange juice and a cookie were not acceptable interventions alone for a blood sugar below 60.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide a complete bed bath for 1 of 5 sampled dependent residents (Resident #232) whose baths were observed. The facility also failed to provide timely incontinent care for 1 of 1 sampled dependent residents (Resident #338) who was continuously observed for timeliness of care. Findings include: 1. The objective of the facility's bed bath procedure, version date 02/2007, was to cleanse, refresh and soothe the resident as well as to stimulate the circulation. In the procedure	F 312	Dependent Facility Residents are receiving complete bed baths and timely incontinent care as evidenced by observations by the administrative nurses and resident interviews conducted by the administrative nurses beginning on 09-07-2012. Observations/audits were completed for Resident #338 on 09-20-2012 and Resident # 232 on 09-12-2012.	9/25/12

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F 312	Continued From page 7 section, it was noted that the face and ears as well as the neck, arms, chest and abdomen should be washed. The thighs, legs and feet were to be washed. The back, buttocks and genitalia were to be washed. Resident #232 was admitted to the facility on 03/04/11 and readmitted on 01/23/12. Cumulative diagnoses included urinary tract infection, diabetes mellitus, hand and shoulder contractures and cerebrovascular accident. The Annual Minimum Data Set (MDS) assessment of 05/08/12 indicated Resident #232 had an indwelling urinary catheter. He needed total assistance for hygiene and bathing. According to the Care Area Assessments (CAA) for this MDS, he triggered in 9 areas including indwelling urinary catheter. Resident #232's care plan, last revised 05/17/12, included a problem with altered pattern of urinary elimination with an indwelling catheter due to the presence of pressure ulcers. There was no problem identified with activities of daily living. An observation of a bed bath was conducted on 08/28/12 beginning at 10:55 AM. It was noted that Resident #232 was uncircumsized. Nurse Aide #6 (NA#6) prepared a basin of warm water, wash cloths and no rinse body wash. He began by washing Resident #232's face and upper body. He changed his basin of water and filled it with clean water. He washed Resident #232's upper	F 312	The Staff Facilitator conducted classes including return demonstration with all nurses and CNA's on 09-10-2012, 09-11-2012, 09-12-2012, 09-13-2012, and 09-14-2012. Related to providing a complete bed bath to include return demonstration of foley catheter care and perineal care of an uncircumcised male. Staff in-servicing by the staff facilitator for timely incontinence care was started on 09-04-2012 and completed on 09/20/2012. New nurses and CNA's will receive education related to complete bed bath and timely incontinence care during orientation to the facility by the staff facilitator.	9/25/12

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F 312	Continued From page 8 legs and toes but did not remove the dark blue foam boots which covered the lower legs and feet bilaterally. He washed each groin but did not wash Resident #232's penis, nor push back the foreskin to cleanse the head. He did not wash Resident #232's scrotom or perineal area. Another aide came into the room to assist with turning Resident #232. Once he was positioned on his right side, NA#6 used a wet cloth and body wash to wash his upper back. It was noted that Resident #232 had a dressing on the coccyx/sacral area that had loosened but was still intact. He used a wash cloth to remove stool from the anal area but did not wash the buttocks or perineum. He assisted Resident #232 to roll back onto his back and placed a clean brief. No mouth care was provided. NA#6 was interviewed after the observation on 08/28/12 at 11:45 AM. He stated he was trained to wash a resident from head to toe. He stated he had been taught to change the bath water before washing the perineum. NA#6 stated he was taught to use a clean wash cloth for the perineal area. NA#6 remarked that he did not wash Resident #232's buttocks/perineal area because he had a dressing in place to the sacral area. He stated he did not want to introduce germs into that area so he did not wash the area at all. NA#6 stated he should have pushed the foreskin back to expose the head of the penis so he could cleanse the area. He stated he did not retract the foreskin nor did he provide adequate bathing. When questioned about removal of the blue foam boots, he stated he should have removed the boots so he could have washed his lower legs and his feet.	F 312	The administrative nurses to include nursing supervisors, staff facilitator and quality improvement nurses will conduct audits of complete bed baths and timely incontinence care to include Resident # 232 and Resident # 338 to insure that complete bed baths are provided and timely incontinence care is provided. A QI tool for complete bed bath and random Resident interviews will be completed three times per weeks for four weeks, then one time per week for four weeks, then one time per month for one month. Any concerns identified will be addressed by the administrative nurse at the time of the audit with follow up to the concerns documented on the QI tool. 9/25/12	

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F 312	Continued From page 9 On 08/28/12 at 2:15 PM, NA#6 stated he had rewashed Resident #232. An interview was conducted with the Nurse #8 (Staff Development Coordinator), on 08/30/12 at 11:30 AM. She stated during orientation the facility's bed bath policy, indwelling urinary catheter care, any activities of daily living tasks that staff were certified to perform, and computer documentation was discussed. She stated a bed bath included all body parts and staff had been taught to wash in a head to toe fashion. Nurse #8 stated all residents were given bed baths unless they were receiving a shower that day. She stated if an aide was providing a complete bed bath and noticed a wound dressing had come loose or was falling off, they should still wash those areas and report to the nurse that the dressing was loose or not intact. They should not omit washing body parts just because a dressing was in place or if a resident had any protective devices such as the bunny boots or foam boots. Nurse #8 stated the boots should be removed to wash the residents lower legs and feet. She stated if a male resident was uncircumsized, aides were taught to push the foreskin back during the bath to ensure cleaning the penis and the meatus. She added this was especially important if the resident had a catheter. She added once the bathing was accomplished the foreskin should be pushed back into place. 2. Resident #338 was admitted to the facility on 08/03/12. Cumulative diagnoses included	F 312	Results of the audits and resident interviews will be reviewed and addressed weekly by the Director of Nursing or designee. The results will be compiled by the QI committee for monthly review for identification of trends, development of action plans and to determine the need or frequency of continuing QI monitoring.	9/25/12

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F 312	Continued From page 10	F 312		

hypertension, congestive heart failure and diabetes mellitus. There was an admission Minimum Data Set (MDS) assessment of 08/10/12 for this resident which indicated he had long and short term memory problems as well as moderately impaired decision making skills. He needed extensive assistance with toilet use and hygiene. He was incontinent of both bowel and bladder.

According to the grievance log, an entry was made on 08/13/12 for Resident #332. The investigation was completed on 08/23/12 and followup had occurred with the family on 08/15/12. The intervention was staff education.

During an interview with Resident #338's family, on 08/29/12 at 3:30 PM, it was reported that she visited daily and every time she visited he was soiled and in need of changing. She stated she usually cleaned him herself as staff did not check on him in a timely manner. She stated she had reported it to the facility staff.

Resident #332 was observed in bed at 8:30 AM on 08/30/12. There were no odors detected.

On 08/30/12 at 9:45 AM, Nurse Aide #7 was observed providing personal care for Resident #338. It was noted that the bed pad underneath him was totally soiled with yellow drainage. There was a strong stool odor detected . NA#7 commented while she was bathing him that he had a very large bowel movement and she was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 11 cleaning him up for his aide (NA#3). NA#7 was interviewed on 08/30/12 at 10:30 AM. She stated the pad that was on his bed was dry and had been left there by third shift. She stated it was not wet. She stated she was helping NA#3 by providing his care for her as she was busy. She stated she checked her residents about every 2 hours. NA#3 was interviewed on 08/30/12 at 10:45 AM. She stated this was the first day she had been assigned to Resident #332. She stated at shift change she did check on him but she did not go into the room and lift the covers to check him. She stated Resident #332 was dependent on staff for care and was unable to tell when he had soiled himself. When questioned how often she checked her residents, she stated every 2 hours but she had not provided care for him since she came on duty. She was not sure what time he had been changed by third shift staff. NA#3 stated the first time she had been in to provide care was when she and NA#7 went in at 9:45AM. A continuous observation for timely incontinent care began at 9:45 AM on 08/30/12. On 08/30/12 at 12:45 PM, family members were observed at bedside. On 08/30/12 at 12:55 PM, NA#6 was observed delivering Resident #332's lunch tray. He placed	F 312		

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F 312	Continued From page 12 it on the overbed table and Resident #332 began to eat his lunch. When NA#6 had finished setting up the tray he began to leave the room. He was asked to check Resident #332 for incontinence. The tray was removed from the room and NA#6 checked to find he was not soiled or wet. The continuous observation ended at 12:55 PM. Resident #332's assigned aide (NA#3) was not observed entering into Resident #332's room throughout the observation time period. The resident liasion reported during an interview on 08/30/12 at 12:00 PM, that Resident #332's family had complained about timely incontinent care. She stated a different family member had visited Resident #332 over the weekend of 08/12/12 and evidently reported to the family that she found him wet on 08/12/12. On 08/13/12, the family filed a grievance about the incident. The liasion stated staff were expected to check residents every 2 to 3 hours or more often if necessary. She also commented that when the family reported the incident on 08/12/12, 3 different staff members responded that he was not their resident. She commented that the visitor asked the charge nurse to provide care and was told they didn't usually change residents. The liasion reported the plan was to monitor more closely and he was moved to a different hall. She commented that all staff were inserviced after the grievance of 08/13/12 was received. The liasion stated the grievance was resolved on 08/15/12. The liasion provided another grievance of 08/24/12 which indicated Resident #332 had been found soiled once again. She added that the assigned aide was to receive disciplinary action for not checking on him. The liasion	F 312		

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F 312	Continued From page 13 provided copies of the inservice that staff had received which included timely incontinent care. During an interview with the Director of Nurses (DON), on 08/30/12 at 5:15PM, she stated staff were inserviced after the incident with Resident #332. She stated staff were expected to check residents at the beginning of their shift and every 2 to 3 hours afterwards. The DON stated residents should be checked prior to meal trays being placed to ensure not soiled or wet before eating. She agreed that if intervention had not occurred, Resident #332 would not have been checked until meal trays were removed.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide adequate catheter care for 1 of 4 sampled residents with an indwelling urinary catheter (Resident #232) whose care was observed. The facility also failed to provide medical justification for the use of an	F 315		

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F 315	Continued From page 14 indwelling urinary catheter for 1 of 4 sampled residents (Resident #96) who had catheters. Findings include: 1. Included in the maintenance section of the facility's procedure for catheterization, version date 02/2007, was to cleanse the meatus and adjacent catheter daily with soap and water. Resident #232 was admitted to the facility on 03/04/11 and readmitted on 01/23/12. Cumulative diagnoses included urinary tract infection, diabetes mellitus, and cerebrovascular accident. The Annual Minimum Data Set (MDS) assessment of 05/08/12 indicated Resident #232 had an indwelling urinary catheter. He needed total assistance for hygiene and bathing. According to the Care Area Assessments (CAA) for this MDS, he triggered in 9 areas including indwelling urinary catheter. Resident #232's care plan, last revised on 05/17/12, identified a problem of altered pattern of urinary elimination with indwelling catheter due to the presence of pressure ulcers. The goal for Resident #232 was to be free from UTI through the next review. Interventions included catheter care per facility protocol. Another intervention was to monitor for signs and symptoms of UTI. It was noted the indwelling urinary catheter size was 14 french with a 5 cc (cubic centimeter) bulb.	F 315	Residents with foley catheters to include Resident # 232 are being provided with adequate catheter care as evidenced by observations conducted by administrative nurses beginning on 09/12/2012. Resident # 96 foley catheter was discontinued on 09-06-2012 related to lack of supportive documentation and medical necessity. Residents with catheters have appropriate medical justification for the use of indwelling urinary catheter as evident by audits of resident's medical record completed on 09-06-2012 by administrative nurses, to ensure presence of an appropriate diagnosis and supportive documentation.	9/25/12

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F 315	Continued From page 15 A physician's telephone order of 06/01/12 indicated to begin Cipro (an antibiotic used to treat UTI) 500 mg (milligrams) twice daily for 7 days for UTI. A urinalysis final laboratory report of 06/06/12 indicated abundant escherichia coli (a germ that lives in the large intestine and found in stool). A physician's telephone order of 06/06/12 indicated to discontinue Cipro and start Primaxin (a broad spectrum antibiotic used to treat bacterial infections) 500 mg intravenously every 6 hours for 10 days for UTI. A urinalysis final report of 07/19/12 indicated a result of > (greater than) 100000 colonies/ml (milliliter) of escherichia coli and proteus mirabilis (a common pathogen which contributes to UTI and found in the intestinal tract). A physician's telephone order of 07/19/12 indicated to begin Ampicillin (antibiotic used to treat UTI) 500 mg three times daily for 10 days for UTI. Included in the August 2012 physician's orders was use of an indwelling urinary catheter for Resident #232. The most recent quarterly Minimum Data Set	F 315	The Staff Facilitator in-serviced nurses and CNA's on adequate catheter care and in-serviced nurses on appropriate diagnosis to support use of a urinary catheter and documentation that must be present in medical record to justify its use. In-servicing was started on 09-04-2012 and completed on 09-20-2012. New nurses will receive education related to adequate catheter care and diagnosis with supportive documentation during orientation to facility by the staff facilitator.	9/25/12

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F 315	Continued From page 16 (MDS) assessment of 08/03/12 indicated he needed extensive assistance with activities of daily living. He had an indwelling urinary catheter and was incontinent of bowel. A physician's telephone order of 08/16/12 indicated to administer Bactrim DS (antibiotic used to treat UTI) twice daily for 7 days for treatment of a UTI for Resident #232. A urinalysis culture and sensitivity final report of 08/18/12 indicated >100000 colonies/ml of escherichia coli and proteus mirabilis. It was noted on the laboratory report that the physician had written Nitrofurantoin (antibiotic used to treat UTI) 100 mg twice daily for 10 days for the Escherichia coli and Ampicillin (antibiotic used to treat UTI) 500 mg three times daily for 10 days for the proteus mirabilis. A physician's telephone order of 08/19/12 indicated to administer Macrodantin (Nitrofurantoin) 100 mg twice daily for 10 days and Ampicillin 500 mg three times daily for 10 days. Resident #232 was in bed on 08/28/12 at 10:55 AM. Nurse Aide #6 (NA#6) was preparing to administer a bed bath. It was noted that Resident #232 was uncircumsized with a large amount of foreskin. The catheter tubing was taped to the inner left thigh. After NA#6 cleansed down both groins of Resident #232, he changed the basin of water and obtained a clean wash cloth. He	F 315	The administrative nurses to include nursing supervisors, staff facilitator and quality improvement nurses will conduct audits of foley catheter care on residents with foley catheters and audit resident medical records to ensure medical justification for use of a urinary catheter. A QI tool will be completed five times per week for two weeks, then three times per week for two weeks, then one time per week for two weeks. Any concerns identified will be addressed by the administrative nurse at the time of the audit with follow up to the concerns documented on the QI tool.	9/25/12

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F 315	Continued From page 17 picked the catheter tubing up, held it approximately 1 inch from where the foreskin was positioned and cleansed the catheter tubing outward and continued to cleanse the drainage tubing downward to the drainage bag. He used a different wash cloth to dry the catheter tubing as well as the drainage tubing down to the drainage bag. He did not touch Resident #232's penis nor did he push the foreskin back to cleanse the head of the penis. He did not cleanse the indwelling urinary catheter tubing at the meatal insertion site. NA#6 was interviewed at 11:45 AM on 08/28/12 about the observation. He stated he had been taught to change the bath water before cleansing the perineum or the catheter tubing. He stated he had been taught to use a clean wash cloth. When questioned as to how he had been taught to cleanse an uncircumsized male resident, he replied that he should have pushed the foreskin back to cleanse the head of the penis and the catheter tubing at the insertion site. He commented that not retracting the foreskin could cause infection. An interview was conducted with Nurse #8, on 08/30/12 at 11:30 AM. She stated during orientation aides were taught the facility's bed bath policy, indwelling urinary catheter care (foley care), any activities of daily living tasks that they were certified to perform, and computer documentation. Nurse #8 stated if a male resident was uncircumsized, aides were expected to push the foreskin back during the bath to ensure cleaning the head of the penis and the	F 315	Results of the audits will be reviewed and addressed weekly by the Director of Nursing or designee. The results will be compiled and forwarded to the Quality Improvement Committee for monthly review for identification of trends, development of action plans and to determine the need and/or frequency of continuing QI monitoring	9/25/12

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F 315	Continued From page 18 meatus. She added this was especially important if the resident had an indwelling urinary catheter. All items used during catheter care should be clean including the wash cloth and the basin of water. Nurse #8 commented staff should wash at least 4 inches from the body outward "tip to base" to cleanse the catheter tubing. She added once the cleaning was accomplished the foreskin should be pushed back into place. She stated staff were taught this procedure in an effort to prevent infections. 2. Resident #96 was admitted to the facility on 12/23/12. There resident's documented diagnoses included benign prostatic hyperplasia (BPH) without urinary obstruction and history of pressure ulcers. Record review revealed a 11/23/11 physician's order which documented Resident #96 was to have an indwelling catheter due to an unstageable sacral pressure ulcer. A 01/24/12 physician's order discontinued the use of Resident #96's indwelling catheter once his pressure ulcer healed. A 05/31/12 step-down hospital Discharge Summary for Resident #96 documented, "Hospital Course: ...For his renal and genitourinary function, for the history of BPH, he was noted to continue on Flomax 0.4 mg (milligrams) daily. Disposition: ...He is noted that he will continue to have a Foley catheter daily	F 315		

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F 315	Continued From page 19 with the diagnosis of BPH." Record review revealed documentation that on 05/31/12 Resident #96 had stage II pressure ulcers on both his right and left buttocks. A 06/01/12 physician's order documented Resident #96 was to have an indwelling catheter due to BPH with urinary retention. Review of laboratory results revealed Resident #96 was diagnosed with three urinary tract infections between 06/07/12 and 08/07/12. Record review revealed documentation that on 06/29/12 the pressure ulcers to Resident #96's right and left buttock had healed. The resident's 08/13/12 Quarterly Minimum Data Set (MDS) documented he was severely cognitively impaired and had an indwelling catheter in place. On 08/20/12 the resident's care plan identified "Altered pattern of urinary elimination with indwelling catheter r/t (due to) dx (diagnosis) of urinary retention" as a problem. At 10:40 AM on 08/30/12 the director of nursing (DON) stated BPH alone was not justification for the continued use of an indwelling catheter. At 2:55 PM on 08/30/12 the DON reported that the facility could find nothing in writing in hospital reports and consults which documented Resident #96 had urinary retention. However, she stated a nurse practitioner, who followed the resident in his May 2012 stay in a step-down hospital and	F 315		

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F 315	Continued From page 20 currently rounded in the facility, reported the resident had an on-going history of urinary retention. According to the DON, she could find no documentation of voiding trials done in the facility to determine post void residuals and provide justification for the continued use of an indwelling catheter for Resident #96.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide contracture management services as evidenced by not placing splinting or protection devices in the hands of 2 of 4 sampled residents (Resident #232 and Resident #5) who were observed with contractures. Findings include: 1. Resident #232 was admitted to the facility on 03/04/11 and readmitted on 01/23/12. Cumulative diagnoses included urinary tract infection, diabetes mellitus, hand and shoulder contractures and cerebrovascular accident. A physician's telephone order of 07/19/12	F 318	Residents in need of contracture management services to include Resident # 232 and Resident # 5 are being provided with splinting devices as indicated per resident care guide. The use of splinting devices or protective devices as appropriate for identified resident were verified to be in use on 09-04-2012 by QI Nurse, will continue to be monitored by the restorative nurse.	9/25/12

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F 318	Continued From page 21 indicated Resident #232 was to receive occupational therapy (OT) 5 times weekly for therapeutic exercises, short wave diathermy, orthotics and contracture management. The most recent quarterly Minimum Data Set assessment of 08/03/12 indicated he needed extensive assistance with activities of daily living. In the restorative nursing section of this assessment, there was no indication that he had received passive range of motion (PROM), active range of motion (AROM) nor splint or brace assistance. He did receive 207 minutes from OT. An OT end of care discharge summary note, dated 08/06/12, indicated Resident #232 was able to wear an orthotic device in his right hand for 6 hours daily with no sign or symptom of pressure. The summary also indicated he had an orthotic device to maintain the extension pattern of his right hand for hygiene and skin integrity. Caregiver training was completed. A physician's telephone order of 08/06/12 indicated to discharge Resident #232 from OT as goals were partially met. During initial tour on 08/26/12 at 5:30 PM, Resident #232 was observed with his right hand clenched tightly without any splinting device in place. Resident #232 was observed in bed on 08/27/12	F 318	The Staff Facilitator in-serviced all nurses and CNA's on the use of splinting and protective devices beginning on 09-04-2012 and completed on 09-20-2012. New nurses and CNA's will receive education related to splinting and protective devices during orientation to the facility by the staff facilitator. The administrative nurses to include nursing supervisors, staff facilitator and quality improvement nurses will conduct audits of splints and protective devices to ensure devices are in place and identified on the care guide.	9/25/12

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F 318	Continued From page 22 at 4:00 PM with his right hand clenched with no splinting or protective device in place. There was an orange "carrot" shaped palm protector noted on his bedside night stand. During another observation of Resident #232 on 08/28/12 at 8:00 AM, he was noted in bed with his right hand clenched tightly and no splinting device in place. The orange "carrot" shaped palm protector was noted on the bedside night stand. During morning care observation of 08/28/12 at 10:55 AM, Resident # 232 was observed receiving a bed bath with his right hand clenched tightly. When NA#6 washed his right hand it was noted that the fingernails were long and he was not able to fully extend his fingers. There was no splinting device in place and the orange "carrot" shaped palm protector was noted on the bed stand next to his bed. The care plan, last revised 08/28/12, identified a problem with mobility related to being at risk for worsening of present contractures. The goal was that contractures of the right hand and wrist would not worsen by the next review. Interventions included application of a palm protector to the right hand daily after hand hygiene. Another problem was identified with mobility related to being at risk for worsening of present contractures which included PROM exercises 7 times weekly to the right hand and wrist.	F 318	A QI tool will be completed a minimum of three times per week for four weeks, then one time per week for four weeks, then one time per month for one month. Any concerns identified will be addressed by the administrative nurse at the time of the audit with follow up to the concerns documented on the QI tool. Results of the audits will be reviewed and addressed weekly by the Director of Nursing or designee. The results will be compiled and forwarded to the Quality Improvement Committee for monthly review for identification of trends, development of action plans and to determine the need and/or frequency of continuing QI monitoring	9/25/12

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F 318	Continued From page 23	F 318		

A restorative nursing evaluation and treatment plan of 08/28/12 indicated for Resident #232's functional status he required total assistance to complete range of motion (ROM) exercises to his right hand/wrist. The problem area was described as decreased ROM to the right hand/wrist requiring total assistance to complete exercises. The goal was to maintain ROM to the right hand/wrist through the next review. Interventions included PROM 1 set 10 repetitions daily, and to document refusals.

A restorative nursing evaluation and treatment plan of 08/28/12 indicated Resident #232 required assistance to apply a splint. The problem area was described as a contracture of the right hand/wrist. Apply splint after PROM daily. The goal noted was no further decline. Interventions included use of a palm protector to the right hand after PROM and hand hygiene daily, monitor skin, and document refusal.

Resident #232 was observed in bed on 08/29/12 at 2:50 PM. The orange "carrot" shaped palm protector was noted on the bed stand next to his bed.

Nurse Aide #3 (NA#3) reported during an interview on 08/29/12 at 2:50 PM that she had noticed the orange "carrot" palm protector in his room so she placed it in his right hand at 12:30 PM today. She stated she usually read the care plan that was inside each resident's closet door for care needs. When asked to look at the care plan, it was noted that there was no mention of

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WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

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F 318	Continued From page 24 any splinting devices or palm protectors on Resident #232's care plan. NA#3 remarked that someone must have removed the "carrot" as Resident #232 was not able to remove it himself. She commented she usually left the "carrot" in his right hand for 2 hours and then she would remove it. During an interview with the Rehab Program Manager on 08/29/12 at 2:10 PM, she stated Resident #232 was placed on therapy caseload for contracture management of his right hand. She stated he was discharged with a "carrot" (an orange carrot shaped protection device) to floor staff earlier this month. She stated several types of splinting devices had been tried in the past but he could not tolerate them so was discharged with the use of the "carrot." The Rehab Program Manager reported that she had spoken with the therapist who discharged Resident #232 and he had reported to her that he trained the floor nurse aides to place the "carrot" into his right hand after the morning bath or shower for up to 6 hours daily. She added that the hall nurse had also been informed of the use of the "carrot" for updating the nurse aides' care plan guides. Nurse #5 was interviewed on 08/29/12 at 3:30 PM. She stated she was responsible for overseeing the restorative program. She stated Resident #232 had been in the restorative program prior to being treated by OT. Nurse #5 stated she had referred him to OT back in June 2012 for an evaluation of his right hand contracture. She added that she was not aware that he had been discharged from OT. When	F 318		

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F 318	Continued From page 25 questioned about how she learned of discharges, she stated she usually received a list of discharges from therapy. Nurse #5 stated she had spoken with therapy yesterday about Resident #232. She commented when he was discharged from OT he should have been discharged back into the restorative program and he wasn't. Nurse #5 commented she did not know anything about the orange "carrot" palm protection device but he did have a palm protector in his room and was to wear it daily. She reported Resident #232 had been placed in the restorative program and RNA#8 would be working with him. At 4:00 PM, Nurse #5 reported she had spoken with therapy and it was decided that a sheepskin lined palm protector would be the better choice for Resident #232 and she displayed the palm protector in her hand. Nurse #6 went into Resident #232's room on 08/29/12 at 3:40 PM to see if there was a splinting device present as she didn't think he had one. She opened the drawers to his bed stand and there was no splinting device found. She pulled back the bed covers to reveal the "carrot" placed in his right hand. Nurse #6 added that if Resident #232 was to have a splint of any type, it would be written on his care plan guide located in his closet. A care plan note written by Nurse #5 dated 08/30/12 indicated that she had discussed the issue regarding Resident #232 's splinting needs with the therapy department and it had been decided that the "carrot" , a rolled up wash cloth or the palm protector would all serve the same	F 318		

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F 318	Continued From page 26 purpose. The note indicated the restorative program was "now in place" . A rehab communication to nursing form of 08/30/12 indicated the barrier to progress was pain in the right hand for Resident #232. Treatment approaches included passive range of motion to the right hand for 15 repetitions. A splinting program included use of a palm protector to the right hand except during hygiene. The short term goal was noted that Resident #232 would wear the palm protector on the right hand at all times except during hygiene. Resident #232 was observed in bed with the sheepskin palm protector in place to his right hand on 08/30/12 at 9:50 AM. Nurse #7 reported during an interview on 08/30/12 at 10:00 AM that Resident #232 did have a "carrot" at one time but she had not seen it in place at all this week. When questioned when she last saw it in his right hand, she responded she did not remember. Nurse #7 added that if residents had splinting devices the restorative aides were responsible for placing them and it was also written on the care plan guide located inside the closet. NA#7 was interviewed on 08/30/12 at 10:30 AM. She stated when she worked with Resident #232 last week he did not have any splinting devices in his right hand. She stated the restorative aides were responsible for placing the "carrots" and any	F 318		

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F 318	Continued From page 27 splints. NA#7 remarked that she used the care plan guides located in the resident's closets to determine her care. She opened Resident #232's closet and it was noted that his care plan guide had been changed to reflect the use of a palm protector. The Restorative NA (RNA#8) was interviewed about Resident #232 on 08/30/12 at 12:50 PM. He stated Resident #232 was placed back into the restorative program as of yesterday. The RNA#8 commented that prior to yesterday, he had worked with Resident #232 and noticed he was beginning to have pain associated with use of the "carrot" device and was referred back to therapy. When questioned if he refused care, he responded that he did not refuse care but he was having pain associated with trying to open his hand to apply the "carrot." He commented that now Resident #232 had a palm protector which he felt was much better for him and so far he tolerated it very well. The RNA#8 remarked that Resident #232 was to wear the palm protector 24 hours daily for 7 days and he was not aware that Resident #232 had been discharged from therapy. During an interview with the Director of Nurses (DON), on 08/30/12 at 3:00 PM, she stated normally when a resident had been discharged from therapy; they had been referred to the restorative program prior to transition to nursing. The DON stated her expectation would have been that staff follow directions given by therapy.	F 318		

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F 318	Continued From page 28 2. Resident #5 was admitted to the facility on 02/17/92 and readmitted on 08/29/11 with cumulative diagnoses of cerebral vascular accident with right sided paralysis, hypertension, peripheral vascular disease, and depression. A quarterly Minimum Data Set (MDS) assessment completed on 06/03/12 identified Resident #5 as having moderate cognitive impairment. Resident #5 was documented as needing extensive assistance of one staff member for bed mobility and transfers and limited assistance with dressing and hygiene. The assessment documented Resident #5 had no rejection of care and did not receive any restorative care for bracing and splinting. An Occupational Therapy Evaluation completed on 02/27/12 the reason for referrral was worsening contractures to right upper extremity. An Occupational Therapy Discharge Summary, dated 04/30/12, indicated Resident #5 received occupational therapy from 02/27/12 until 04/30/12 for right upper extremity contractures and splinting. On discharge from occupational therapy, Resident #5 had demonstrated the ability to recall the times the splints were to be worn and the abilty to doff (remove) the splints after the appropriate time worn. Per the summary, nursing staff had been educated regarding the application of the splints and a copy of the splint protocol had been posted inside Resident #5's closet door.	F 318		

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F 318	Continued From page 29 Review of Resident #5 's current care plan, updated 06/12/12, did not address contractures or splinting of the right upper extremity. Review of a RESIDENT CARE GUIDE (tool used to direct resident care) posted inside Resident #5's closet door, under the Additional Information, documented right hand brace. Above the care guide was a handwritten Splint Schedule which directed on Monday, Wednesday, and Friday, a right elbow bean bag splint and a blue carrot was to be placed in right hand; and on Tuesday and Thursday a light blue wrist splint was to be put on right arm. Review of Resident #5's progress notes from 04/30/12 to 08/30/12 did not document any refusals to wear splints to right arm and wrist. Observations of Resident #5 made on Tuesday 08/28/12 at 8:10 AM, 11:30 AM, and at 4:15 PM, revealed Resident #5's right arm to be pulled up to her chest area and her right hand closed with her third and fourth fingernails to be pressing into her palm. Resident #5 did not have any splints present. In an interview with Resident #5 on 08/28/12 at 4:15PM, when asked if she had any splints, Resident #5 said in the bottom drawer of her bedside table. When asked if she wore them on at all, she said "no." When asked if she would allow staff to put something in her right hand to prevent her fingernails from pressing into her	F 318		

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F 318	Continued From page 30 hand, Resident #5 responded "yes." Observations made on Wednesday 08/28/12 at 8:08 AM, 1:30 PM, and 4:50 PM, revealed Resident #5's right arm to be pulled up to her chest area and her right hand closed with her third and fourth fingernails to be pressing into her palm. Resident #5 did not have any splints present. Observations made on 08/30/12 at 8:20 AM and 10:00 AM, revealed Resident #5's right arm to be pulled up to her chest area and her right hand closed with her third and fourth fingernails to be pressing into her palm. Resident #5 did not have any splints present. An interview was conducted with the Rehab Program Manager on 08/30/12 at 11:25 AM. The Rehab Program Manager said historically Resident #5 had refused the restorative staff to apply any splinting so when she had been discharged from therapy on 04/30/12, she had been transitioned to floor staff which had been trained by the occupational therapist in donning (applying) the right arm splints per the schedule set up and placed inside Resident #5's closet door. The Rehab Program Manager said it had been her expectation that the nursing staff had continued to follow the schedule set up and Resident #5 had been wearing the splints dispensed. On 08/30/12 at 11:35AM, an observation was	F 318		

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F 318	Continued From page 31 made with the Rehab Program Manager of Resident #5. Resident #5 was sitting in a wheelchair at her bedside with her right arm drawn up and her third and fourth fingernails pressing into the palm of her hand. The Rehab Program Manager asked Resident #5 where her splints were and Resident #5 pointed towards the bottom drawer of the bedside table. The Rehab Program Manager removed three devices from the bedside table and asked Resident #5 if staff offered to put the devices on. Resident #5 said "no." The Rehab Program Manager held up the right elbow bean bag splint and the carrot and Resident #5 said she did not want them. When the Rehab Program Manager held up the light blue wrist splint, Resident #5 said she would wear that one. Resident #5 denied having any pain with the splint and denied refusing to wear the wrist splint. In an interview with Nurse #1 on 08/30/12 at 11:55 AM, she said each resident had a RESIDENT CARE GUIDE posted inside their closet door which directed what care a resident needed and if they needed any braces or splints it should be documented there. Nurse #1 said if a resident refused splinting it should be reported to her so she could notify the physician, responsible party, therapy and document it. Nurse #1 said Restorative usually took care of the splint applications and staff had not reported any refusals to her. Nurse #1 said she was not sure when she last saw a splint on Resident #5's right arm or wrist. Nurse #1 said staff had not reported anything to her about Resident #5's splints or refusal to wear them.	F 318		

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F 318	Continued From page 32 In an interview with Nurse #5 on 08/30/12 at 12:10 PM, she said she oversaw the restorative program at the facility. Nurse #5 said she had not received a referral from therapy when Resident #5 had been discharged from therapy and Resident #5 had not been on a restorative program but had been transitioned directly to nursing for her splinting schedule as she had refused restorative care in the past. During an interview with Nurse Aide (NA) #1 on 08/30/12 at 12:15 PM, NA #1 said she would look on the RESIDENT CARE GUIDE posted inside a resident's closet for direction on what a resident needed. NA #1 said she would not do anything with a resident's splint as it had been restoratives responsibility to apply a residents splints. NA #1 said she saw splints on Resident #5's right arm in the past, but none recently. NA #1 said she had not questioned anyone why Resident #5 did not have the splints on. In an interview with the Director of Nurses (DON) on 08/30/12 at 3:00 PM, she said normally when a resident had been discharged from therapy; they had been referred to the restorative program prior to transition to nursing. The DON said she had not been aware of Resident #5's discharge to nursing but her expectation would have been to follow the splinting schedule as directed by therapy to prevent further contractures and prevent Resident #5's fingernails from pressing into the palm of her right hand.	F 318		

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F 318	Continued From page 33 In a telephone interview with the Occupational Therapist (OT) #1 on 08/30/12 at 3:25 PM, she said she had discharged Resident #5 with a splint management program. OT #1 said it had been at Resident #5's request that she not be discharged to restorative but to nursing staff for the application of the splints after morning care per schedule. The OT #1 said she had trained the floor staff to don Resident #5's splints as directed Monday through Friday and Resident #5 had demonstrated understanding and the ability to remove the splints after the appropriate time. The OT #1 said she had been unable to recall the names of the staff that had received training. The OT #1 said it had been her expectation the splint schedule had been followed to prevent further contractures and prevent Resident #5's fingernails from pressing into the palm of her hand. OT #1 said it had not been reported to her that Resident #5 had refused to follow the splinting schedule or any problems with staff adherence to the schedule.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	Residents with orders for snacks to include Resident # 96 are receiving snacks as ordered by the physician. All diet orders for facility Residents were reviewed and compared with Dietary Snack list on 08-29-2012 by administrative nurses to ensure Residents are receiving snacks as ordered for prevention of weight loss.	9/25/12

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F 325	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide snacks which were ordered by the physician to help prevent further weight loss for 1 of 5 sampled residents (Resident #96) who experienced weight loss. Findings include: Resident #96 was admitted to the facility on 12/23/12. There resident's documented diagnoses included adult failure to thrive, protein-calorie malnutrition, and diabetes. Resident #96's electronic Weight Summary documented on 01/06/12 he weighed 141 pounds, on 02/10/12 he weighed 151 pounds, on 03/12/12 he weighed 148 pounds, and on 04/10/12 he weighed 147 pounds. A 05/07/12 dietary assessment documented Resident #96 received a ground, no-concentrated sweet diet with a nightly snack and two scoops of beneprotein supplement three times daily. It also documented the resident was leaving 25% of his food uneaten at most meals, and experienced a 5% weight loss or gain in 30 days. According to the assessment, the resident currently weighed 156 pounds, and was feeding himself with poor intake. The resident's nutritional requirements were calculated as 1863 calories and 85 grams of protein daily. His actual nutritional intake was calculated as 376 calories and 46 grams of protein daily. Resident #96's electronic Weight Summary documented on 06/06/12 he weighed 152 pounds and on 07/11/12 he weighed 132 pounds.	F 325	The Staff Facilitator in-serviced all nurses and medication aides on Dietary Slips and supplements beginning on 09-04-2012 and completed on 09-20-2012. New nurses and medication aides will receive education related to Dietary slips and supplements/snacks during orientation to the facility by the staff facilitator. The administrative nurses to include nursing supervisors, staff facilitator and quality improvement nurses will conduct audits of snacks and supplements to ensure that orders are communicated to dietary.	9/25/12

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F 325	Continued From page 35 A 07/12/12 physician order began Resident #96 on diabetic snacks three times daily (TID) between meals. A 07/17/12 Progress Note written by the facility's registered dietitian documented, "CBW 132# (current body weight 132 pounds) -13% x 30 days, -10% x 90 days, -6.3% x 180 days. Resident reweighed and continues with wt (weight) loss. Nurse implemented DM (diabetic) snack tid b/t (between) meals. PO (intake by mouth) has decreased in past month, skin intact. No edema reported at this time. Recommendations: Will continue to monitor per protocol. Intervention implemented 7/12/12." Resident #96's electronic Weight Summary documented on 08/09/12 he weighed 131 pounds. A 08/13/12 dietary assessment documented Resident #96 received a diabetic snack TID, was leaving 25% of his meals uneaten, was on a planned weight gain program, and experienced a 10% weight loss in 180 days. The resident's calculated nutritional requirements were 1651 calories and 71 grams of protein daily. The resident's actual nutritional intake was calculated as 1414 calories and 61 grams of protein daily. The resident's 08/13/12 Quarterly Minimum Data Set (MDS) documented he was severely cognitively impaired, required limited assistance by a staff member with eating, and experienced a weight loss of 5% or more in the last month or a weight loss of 10% or more in the last six months.	F 325	A QI tool will be completed two times per week for four weeks, then one time per week for four weeks, then one time per month for one month and continued per QI nurse as indicated. Any concerns identified will be addressed by the administrative nurse at the time of the audit with follow up to the concerns documented on the QI tool. Results of the audits will be reviewed and addressed weekly by the Director of Nursing or designee. The results will be compiled and forwarded to the Quality Improvement Committee for monthly review for identification of trends, development of action plans and to determine the need and/or frequency of continuing QI monitoring	9/25/12

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F 325	Continued From page 36 On 08/20/12 "State of nourishment less than body requirement characterized by inadequate intake related to: Leaves 25% or more of food uneaten at most meals, actual weight loss, down 17 # (pounds) x 180 days" was identified as a problem on the resident's care plan. Interventions to this problem included "Assess for/provide food preferences" and "Diet as ordered." Resident #96's electronic Weight Summary documented on 08/23/12 he weighed 128 pounds. On 08/29/12 a review of a computer-generated list of residents receiving physician-ordered snacks revealed Resident #96 did not appear on the list at all. At 3:02 PM on 08/29/12 nursing assistant (NA) #3, who cared for Resident #96 on first shift, stated the resident did not receive snacks between breakfast and lunch and between lunch and supper. At 4:06 PM on 08/29/12 NA #5, who cared for Resident #96 on second shift, stated the resident did not receive an evening snack before bed with his name on it, which indicated a physician had ordered it for him. However, she reported occasionally before bed the resident would take something off the snack cart such as juice and a cookie. At 4:45 PM on 08/29/12, after looking up information on the computer about diet and snacks, the dietary manager (DM) reported Resident #96 was not receiving snacks three times daily from dietary. She reported the nurse	F 325		

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	345113	A. BUILDING _____ B. WING _____	C 08/30/2012

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F 325	Continued From page 37 who took an order for supplements and other weight loss interventions was supposed to transpose the information on a Diet Order form and provide it to the dietary department. The DM reviewed all the Diet Orders she had on file for Resident #96, and commented she did not have a Diet Order documenting the resident was supposed to receive snacks TID. At 4:48 PM on 08/29/12 the RD stated diabetic snacks TID was a very appropriate weight loss intervention for Resident #96. She reported she liked to start residents who experienced weight loss out on additional food such as snacks or favorite foods. Then if the residents continued to lose weight, she explained she liked to add liquid supplement products with medication pass. According to the RD, just because a resident had a diagnosis of adult failure to thrive did not mean that supplemental interventions should not be put in place to help promote weight gain or to help prevent further weight loss. At 8:47 AM on 08/30/12 the director of nursing (DON) stated the nurse who took a physician order for supplements or weight loss interventions should complete a Diet Order form to relay the information to the dietary department. She reported the facility did periodic audits to compare physician orders against Diet Orders turned into dietary. Resident #96's electronic Weight Summary documented on 08/30/12 he weighed 133 pounds.	F 325		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

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F 328	Continued From page 38 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide/schedule podiatry services for 1 of 4 sampled residents (Resident #198) whose care was observed. Findings include: Resident #198 was admitted to the facility on 11/16/10 and readmitted on 07/16/12. The resident's documented diagnoses included dementia, diabetes, muscle weakness, and rheumatoid arthritis. The resident's 07/16/12 Annual Minimum Data Set (MDS) documented the resident had short and long term memory impairment, required extensive assistance by a staff member for personal hygiene, and rejected care periodically. On 07/27/12 "Problematic manner in which resident acts characterized by refusal of care at	F 328	Residents to include Resident # 198 were screened for the need of nail care and/or podiatry services on 09-05-2012 and have been scheduled for podiatry services or had nail care provided. Resident # 198 was seen on 09-14-2012 by Onsite Podiatry Services. The Staff Facilitator in-serviced all nurses and CNA's on the bed bath process to include identification of the need for nail care and/or the need of podiatry services with return demonstration on 09-10-2012, 09-11-2012, 09-12-2012, 09-13-2012 and 09-14-2012.	9/25/12

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F 328	Continued From page 39 times" was identified as a problem in the resident's care plan. Interventions to this problem included, "If resident refuses care, leave resident and return later if possible." At 10:07 AM on 08/28/12 Resident #198's bath was observed. The resident's toenails were long, at least a 1/4 of an inch from the end of the toes, and mycotic. The nursing assistant (NA) providing the bath reported she was unsure which staff members were responsible for cutting toenails. At 8:09 AM on 08/29/12 a family member of Resident #198 stated the staff cut the resident's fingernails yesterday without any resistance from the resident. At 11:06 AM on 08/29/12 the ward clerk (WC) #1/transporter, who coordinated podiatry consults, stated the next time contracted podiatry services would be in the building was on 09/14/12. She provided a list of residents to be seen on that date, and Resident #198 did not appear on the list. The WC reported she could add residents to the list compiled by the podiatry service, but additional names were mostly added per resident or family requests. She commented the only resident added to the 09/14/12 list was actually a resident that the family preferred to be seen by an outside podiatry service. At 11:14 AM on 08/29/12 the director of nursing (DON) examined Resident #198's feet, and	F 328	New Nurses are CNA's will receive education related to the need of nail care and/or podiatry services during orientation to the facility by the staff facilitator. The administrative nurses to include nursing supervisors, staff facilitator and quality improvement nurses will conduct audits to identify the need for nail care/podiatry services to ensure that nail care is provided and/or podiatry services are provided as indicated for each resident.	9/25/12

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F 328	Continued From page 40 reported the resident's toe nails needed to be cut. The DON commented most of the resident's toe nails extended at a 1/4 inch or little more beyond the end of the resident's toes, were mycotic, and were very thick. She also commented some of the nails curved downward toward and into the skin. According to the DON, toenails were cut as needed, and were not cut on a set schedule. She stated the toenails of non-diabetic residents could be cut by NAs, the toenails of diabetic residents could be cut by nurses, but mycotic toenails really needed to be cut by podiatry services. At 11:39 AM on 08/29/12 the DON reported about three weeks ago a nurse trimmed what she could of Resident #198's toenails. According to the DON, when NAs observed long toenails while bathing residents they were supposed to tell the hall nurse who could cut them or seek services to cut them. At 3:13 PM on 08/29/12 NA #4 stated Resident #198 was moody, and sometimes did not want staff touching her. On these occasions, the NA reported the resident might refuse incontinent care or bed baths. However, the NA commented most of the time if you reapproached the resident an hour or so later, she cooperated and care could be completed. According to NA #4, she noticed that Resident #198's toenails were long, and told the nurse. She stated that only nurses could cut toenails, but when toenails were thick and mycotic like Resident #198's, they had to be cut by the foot doctor.	F 328	A QI tool will be completed three times per week for four weeks, then one time per week for four weeks, then one time per month for one month and continued per QI nurse as indicated. Any concerns identified will be addressed by the administrative nurse at the time of the audit with follow up to the concerns documented on the QI tool. Results of the audits will be reviewed and addressed weekly by the Director of Nursing or designee. The results will be compiled and forwarded to the Quality Improvement Committee for monthly review for identification of trends, development of action plans and to determine the need and/or frequency of continuing QI monitoring	9/25/12

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F 328	Continued From page 41 At 8:47 AM on 08/30/12 the DON stated when residents became combative or resisted care staff was trained to make sure the residents were safe, to leave the residents temporarily, to notify a nurse or supervisor, and to reapproach the residents again later. The DON reported staff might need to reapproach residents more than once to get care done, or they might need to ask other staff members to try and complete the tasks.	F 328		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep cold foods containing mayonnaise at or below 41 degrees Fahrenheit during the operation of the trayline and failed to prevent cross contamination at the dish machine. Findings include: 1. At 5:34 PM on 08/26/12 there were hot soups on either end of the steam table, and cold foods were on ice in the steam wells in between the soups. A calibrated thermometer used to check the temperature of tuna salad registered 50	F 371	The regular and puree tuna salad and pimento cheese were removed for the serving line for the evening meal on 8/26/12. A substitute was served. Residents that received the one food cart were assessed on 8/27/12 charge nurse. No concerns were noted related to being served the evening meal on the previous day. All dietary staff were re-educated by the dietary manager related to prevention of cross contamination at the dish machine while setting up trays.	

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F 371	Continued From page 42 degrees Fahrenheit. In addition, the thermometer registered 66 degrees Fahrenheit when checking the puree tuna salad and 47 degrees Fahrenheit when checking the pimento cheese. At this time the cook reported the trayline started operation at 5:00 PM. Review of the Steam Table Food Temperature log revealed no food temperatures were recorded as the trayline began operation for the supper meal on 08/26/12. At 8:55 AM on 08/29/12 the dietary manager (DM) stated the cold salads served on 08/26/12 were prepared that same day, with preparation on the salads starting at about 1:00 PM. She reported once assembled, the cook placed the salads in the walk-in freezer. According to the DM, cold salads containing mayonnaise were supposed to be prepared the day before being served. She also commented the temperatures should be taken on all hot and cold foods right before the trayline operation began, and recorded in the temperature log. Ideally the DM explained the hot foods should be placed on one side of the divided steam table, and cold foods should be placed on the other side of the divided steam table. She also commented the salads should be kept on ice during the entire operation of the trayline, and should be maintained at 41 degrees Fahrenheit or below. According to the DM, only one meal cart had left the kitchen before 08/26/12 temperatures were taken on cold salads. At 9:50 AM on 08/30/12 the DM stated the facility made the tuna salad and pimento cheese which were not kept at the trayline at or below 41 degrees Fahrenheit on 08/26/12. She reported the tuna salad contained tuna, eggs, mayonnaise, and pickles, and the pimento cheese contained	F 371	All Dietary staff were re-educated by the dietary manager by 8/30/12 related to proper temperatures for serving hot and cold food. The inservice also included preparation of cold foods the night before and storing them in the walk-in cooler to ensure 41 degree or below serving temperatures for the next day. Food temperature logs will be audited daily x 7 days, 5 x weekly x 3 weeks, then weekly x 8 weeks by the dietary manager/assistant manager to ensure food temperatures are being taken prior to meal service , recorded and food is served within safe serve temperatures. The results of the audit will be recorded on the Food Temperature/Cross Contamination Audit Log.	9/25/12

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F 371	Continued From page 43 cheese, pimento, and salad dressing. According to the DM, in-services were held monthly for all employees in the dietary department. She stated the appropriate trayline temperatures and the importance of logging those temperatures were covered in an April 2012 in-service on foodborne illness and a May 2012 in-service about trayline operation. At 10:05 AM on 08/30/12 a dietary employee, who sometimes cooked, stated cold salads made with mayonnaise should be prepared the night before they were served. She explained the salads were to be stored in the walk-in refrigerator overnight, and were to be brought out of refrigeration just before trayline operation began. The employee also reported the temperature of all hot and cold foods should be recorded in the log book before the trayline started. She commented the cold salads were to be stored on ice in containers on the food preparation tables during the entire operation of the trayline. 2. In observations on 08/29/12 between 9:03 AM and 9:30 AM the dietary aide who was unloading sanitized kitchenware from the dish machine was setting up meal trays between removing racks from the dish machine. She placed packaged crackers, straws, packets of sugar and sugar substitute, salt packets, and sugar packets on trays, and did not wash her hands before touching dishes in three racks as she placed them at the trayline for the next meal. At this time the DM stated she could see how the kitchenware could be contaminated since the aide did not wash her hands before directly touching the plates.	F 371	Dietary aides will be monitored by the dietary manager or assistant manager to ensure they are not cross contaminating clean items while multitasking in the kitchen. A cross contamination QI audit tool will be used daily x 7 days, 5 x weekly x 3 weeks, then weekly x 8 weeks. The results of the audit will be reviewed by the Quality Improvement Nurse weekly x 12. The results will be compiled and forwarded to the Quality Improvement Committee for monthly review for identification of trends, development of action plans and to determine the need and / or frequency of continuing of monitoring.	9/25/12

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F 371	Continued From page 44 At 9:50 AM on 08/30/12 the DM stated dietary in-services were held monthly, and all dietary employees attended them. She reported touching sanitized kitchenware with contaminated hands that had not been washed or sanitized was not acceptable. According to the DM, on 05/17/12 an in-service was provided concerning the dish machine process and cross contamination. During this in-service the DM commented staff were told that they should not go between dirty and clean kitchenware without washing their hands. At 10:05 AM on 08/30/12 a dietary employee, who sometimes worked at the dish machine, stated she had been trained to wash her hands, if completing other tasks, before handling sanitized kitchenware.	F 371		

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Willow Creek acknowleges receipt Of the Statement fo Deficiencies And proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents.. The Plan of Correction is submitted as a written allegation of compliance.Willow Creek's response to the Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any of the deficiencies is accurate. Further, Willow Creek reserves the right to refute any of the deficiencies on this Statement of Deficiencies Through Informal Dispute Resolution, formal appeal And/or legal proceeding.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations and staff interview at	K 018		12-14-12

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CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

11-16-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 approximately 9:30 am onward, the following items were noncompliant, specific findings include: clean linen room door on 100 hall and resident room 303 door did not close and latch for smoke tight seal. 42 CFR 483.70(a)	K 018	K029 (1) The dry storage door in the kitchen was adjusted to close and latch properly.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: soiled linen room door beside fire alarm control panel was held open with floor sign. Also, dry storage door in kitchen would not close and latch. 42 CFR 483.70(a)	K 029	(2) All doors were checked and adjusted as needed to ensure proper closing and latching. All doors were checked to ensure they were not propped open. All staff were inserviced not to prop doors. (3) The monthly door checklist with be brought to the monthly Quality Improvement meeting for three consecutive months and then will be reevaluated. All new orientees will be educated that doors can not be propped open. (4) The monthly checklist with be brought to the monthly Quality Improvement meeting for three consecutive months and then will be reevaluated	12-14-12
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section	K 038		12-14-12

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K 038	Continued From page 2 7.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: exit door going out of gym on 100 hall required more than 15 pounds of force to open . 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 038 K 051	K038 (1) The exit door from 100 hall therapy gym was adjusted to open with less than 15-pounds of force (2) All exit doors in main building 01 were checked to ensure that they open with less than 15-pounds of force (3) All exit doors in main bldg 01 will be checked at least monthly by the maintenance director or designee to ensure to open with less than 15-pounds of force (4) The monthly door checklist with be brought to the monthly Quality Improvement meeting for three consecutive months and then will be reevaluated.	12-14-12
K 051 SS=E				

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 051	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: manual pull stations on 100,200 and 300 hall are mounted over 48 inches from floor. 42 CFR 483.70(a)	K 051	K051 (1) Manual fire alarm pull stations will be re-mounted within 48" from the floor on 100, 200, and 300 halls (2) All manual fire alarm pull stations will be checked to ensure that they are mounted within 48" from the floor	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include; facility will need to provide documentation on how the two wet sprinkler systems in attic will be protected from freezing. 42 CFR 483.70(a)	K 062	(3) Any new manual fire alarm pull station will be supervised by the Maintenance Director to ensure they are installed within 48" from the floor (4) Any new manual fire alarm pull station will be verified by the Maintenance Director or designee to be within 48" from the floor and brought to the Quality Improvement meeting for three consecutive months and then reevaluated	12-14-12
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064		12-14-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 064	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: portable fire extinguishers in building 1,2 and 3 are mounted over 5' from floor level.	K 064	K064 (1) Portable fire extinguishers in buildings 01, 02 and 03 will be remounted within 5-feet of the floor (2) Portable fire extinguishers in buildings 01, 02 and 03 will be remounted within 5-feet of the floor (3) The Maintenance Director or designee will supervise any new fire extinguisher mounting or replacement mounting to ensure mounted within 5-feet of the floor. (4) All repairs or additional fire extinguisher mounts will be brought to the Quality Improvement Meeting for the next two consecutive quarters.	
K 069 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: deep fat fryer in kitchen has no splash guard on fryer.	K 069		12-14-12
K 147 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings	K 147		12-14-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 5 include: residents rooms 103; 111 were using drop cords for electrical supply on window a/c units and for TV(all rooms with windows unit are using drop cords). 42 CFR 483.70(a)	K 147	K147 (1) Drop cords were removed from resident rooms 103 and 111 (2) All rooms were inspected for drop cords and if found, cords removed (3) All rooms will be inspected for drop cords at least weekly by Maintenance Director or designee. If cords found, they will be removed (4) Room inspections for drop cords will brought to the monthly Quality Improvement meeting monthly for two consecutive quarters and then re-evaluated	12-14-12

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	345113	A. BUILDING 02 - BUILDING 02 B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: soiled linen room door was held open with wet floor sign(beside fire alarm control panel). 42 CFR 483.70(a)	K 029	K029 (1) Door props were immediately removed (2) All doors were checked to ensure that no others were propped. (3) Doors will be checked at least weekly to ensure they are not propped open. All current staff and new orientees will be educated that doors can not be propped open.	12-14-12
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the	K 051	(4) The monthly checklist with be brought to the monthly Quality Improvement meeting for three consecutive months and then will be reevaluated	12-14-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Bill Mullinix — 11-16-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING 02 - BUILDING 02 B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

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K 051	Continued From page 1 path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: manual pull stations in building 2 also mounted 48 above floor. 42 CFR 483.70(a)	K 051	K051 (1) Manual fire alarm pull stations will be re-mounted within 48" from the floor on 100, 200, and 300 halls (2) All manual fire alarm pull stations will be checked to ensure that they are mounted within 48" from the floor (3) Any new manual fire alarm pull station will be supervised by the Maintenance Director to ensure they are installed within 48" from the floor (4) Any new manual fire alarm pull station will be verified by the Maintenance Director or designee to be within 48" from the floor and brought to the Quality Improvement meeting for three consecutive months and then reevaluated	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871	K 062		12-14-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING 02 - BUILDING 02 B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

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K 062	Continued From page 2 Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: sprinkler heads at nurse station #3 have paint on orifice.	K 062	K062 (1) The Sprinkler heads at nurses station #3 will be replaced by a contracted vendor	
K 067 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: fire/smoke damper throughout facility have excess lent on fuse link.	K 067	(2) All sprinkler heads will be checked to ensure they do not have paint on orifice (3) Maintenance Director or designee will check all sprinkler heads at least weekly to ensure they do not have paint on orifice. Maintenance Director will in-service painter on proper technique to ensure paint does not get on the sprinkler heads	12-14-12
K 144 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	(4) Sprinkler head checklist will be brought to the monthly Quality Improvement Meeting for two consecutive quarters and then re-evaluated	12-14-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING 02 - BUILDING 02 B. WING _____	10/30/2012

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WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

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K 144	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: annunciation panel across from nurse station on 400 hall did not have audible signal when generator was on test. 42 CFR 483.70(a)	K 144	K144 (1) Contacted outside vendor to repair annunciation panel (2) An audible signal for the generator test panel will be repaired and tested by outside vendor (3) Maintenance Director or designee will monitor panel at least monthly to ensure working correctly (4) Monthly checklist with be brought to the Quality Improvement Meeting monthly for two consecutive quarters and then reevaluated	12-14-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	345113	A. BUILDING 03 - BUILDING 03 B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

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K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: soiled linen room door did not close and latch for smoke tight seal(nurse station 4). 42 CFR 483.70(a)	K 029	K029 (1) Soiled linen room door was adjusted to close and latch for smoke tight seal (2) All doors in were checked to ensure for proper closure & latching for a smoke tight seal (3) All doors will be checked at least monthly by the maintenance director or designee to ensure closure & latching for a smoke tight seal (4) The monthly door checklist with be brought to the monthly Quality Improvement meeting for three consecutive months and then will be reevaluated	12-14-12
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: med. refrigrator at nurse station 4 was	K 147		12-14-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Bill Mullis | 11-16-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING 03 - BUILDING 03 B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

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K 147	Continued From page 1 not on emergency power.. 42 CFR 483.70(a)	K 147	K147 (1) Nursing refrigerator at station four relocated to an emergency electrical outlet (2) Check all nursing refrigerators to ensure they are on an emergency electrical outlet (3) At least monthly Maintenance Director or designee will monitor to ensure nursing refrigerators are on an emergency electrical outlet (4) The monitoring tool will be brought to the Quality Improvement meeting on a monthly basis for two consecutive quarters and then reevaluated	12-14-12