STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Creek Nursing and Rehabilitation Center	**2401 Wayne Memorial Drive , Goldsboro, North Carolina, 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
E0004 SS = F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.	E0004	E0004 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 04/03/2026, the Administrator and Quality Assurance Committee updated and reviewed the emergency preparedness plan (EP). The facility consultant validated completion and review of the EP plan on 04/03/2026. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 04/03/2026, the Administrator completed an audit of EP plan reviews for the past 2 years with no additional concerns identified. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 04/03/2026 the facility consultant in-serviced the Administrator on the responsibility to establish and maintain a comprehensive emergency preparedness program that meets Federal, State and local requirements. The in-service also included that the emergency plan must be reviewed and updated at least annually and with policy changes as indicated. EP education will be provided for all newly hired administrators and assistant administrators during orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator with oversite of the facility consultant will complete a review of the EP plan monthly x 3 months to ensure the facility establishes and maintains a comprehensive emergency preparedness program that meets Federal, State and local requirements to include annual review and updates with policy changes. The Administrator and facility consultant will address all concerns identified during the audit to include updating and reviewing the EP when indicated and retraining of staff. The Director of	04/07/2026

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 reverse for further 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.

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

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E0004 SS = F	Continued from page 1 . This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to review and update their Emergency Preparedness (EP) plan annually. The deficient practice had the potential to affect all residents residing in the facility. Review of the EP plan provided by the facility revealed it was dated January 2025. During an interview on 3/19/26 at 9:00 AM with the Administrator, he stated he started working at the facility one week prior to the survey (March 2026). He also stated he was not aware the emergency preparedness plan had not been reviewed annually. The Administrator added he would have been responsible for reviewing the EP plan and he had not yet reviewed the EP plan.	E0004	Continued from page 1 Nursing (DON) will review the EP monthly x 3 months to ensure all areas of concern are addressed. The Administrator will present the findings of the EP review to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months for review and to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of Compliance: April 7th, 2026.	
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/16/26 through 3/19/26. Event ID# 1F336E-H1. The following intakes were investigated 2743059, 816105, 2606200, 2611385, 816103, 2638659, 2806713. 8 of the 8 complaint allegations did not result in deficiency.	F0000		04/07/2026
F0584 SS = B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F0584	F584 Safe/Clean/Comfortable/Homelike Environment 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 03/19/26, Resident #18's privacy curtain with dark brown/red marks was removed and replaced by the Housekeeping Director. The removed curtain was sent to laundry services for proper cleaning. On 03/19/2026, Resident #79's oxygen concentrator with white particles on the top surface was cleaned and disinfected on 3/19/26, removing all visible debris and particles by the Housekeeping Manager with oversite from the Administrator. On 3/19/26, Resident #160's the dark red marks resembling a dripping pattern on the wall were cleaned and disinfected by the housekeeping manager. 2. Address how the facility will identify other	04/07/2026

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F0584 SS = B	Continued from page 2 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, and record review the facility failed to clean and maintain privacy curtains, oxygen concentrators, and walls in resident rooms for 3 of 44 resident rooms (Resident #18, Resident #79, and Resident #160) on 2 of 11 halls (200 and 300 Halls) observed for environment. The findings included: a. Resident #18's quarterly Minimum Data Set (MDS) assessment dated 3/12/26 revealed that she was severely cognitively impaired. An observation of Resident #18's room, located on the 300 hall, on 3/16/26 at 11:26 AM revealed there were two privacy curtains located around the resident's bed and the curtain closest to the window displayed multiple dark brown/red stains.	F0584	Continued from page 2 residents having the potential to be affected by the same deficient practice. On 04/03/2026, the Administrator initiated an environmental audit of all resident rooms to include privacy curtains, oxygen concentrators and other equipment surfaces, walls around beds and high-contact areas. This audit was conducted to ensure these areas were cleaned and maintained in accordance with environmental services standards. Any identified concerns were immediately cleaned, repaired, or replaced as needed. The audit will be completed by 04/03/2026, 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 04/03/2026, the Administrator initiated an in-service with the Housekeeping Manager and Housekeeping staff regarding Maintaining a Homelike Environment with emphasis inspection of privacy curtains for stains or soiling, cleaning of oxygen concentrators and medical equipment surfaces, and inspection of walls in resident rooms, especially near beds and mobility areas. The in-service will be completed by 04/06/2026. After 04/06/2026, any staff who has not received the in-service will complete the in-service on the next scheduled work shift. All newly hired housekeeping staff will be educated during orientation regarding Maintaining a Homelike Environment. On 04/03/2026, the Staff Development Coordinator initiated an in-service with all nurses, nursing assistants, therapy staff, accounts payable, accounts receivable, social worker, administrator, activity staff, receptionist, scheduler, and medical records director regarding Safe and Homelike Environment with emphasis on identifying soiled curtains, equipment, or walls and immediately reporting environmental concerns to housekeeping. The in-service will be completed by 04/06/2026. After 04/06/2026, any staff who has not received the in-service will complete the in-service on the next scheduled work shift. All newly hired nurses, nursing assistants, therapy staff, accounts payable, accounts receivable, social worker, administrator, activity staff, receptionist, scheduler, and medical records director will be educated during orientation regarding Maintaining a Homelike Environment. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

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F0584 SS = B	Continued from page 3 An additional observation of Resident #18's room was conducted on 3/19/26 at 8:45 AM and revealed that the privacy curtain closest to the window displayed multiple dark brown/red stains. An observation of Resident #18's room was conducted during an interview with Housekeeper #1 on 3/19/26 at 8:49 AM. She revealed that she was assigned to Resident # 18's room on 3/17/26 and 3/18/26. She indicated that she was the staff responsible for replacing privacy curtains if they were dirty/soiled. Housekeeper #1 confirmed that the privacy curtain closest to the window in Resident #18's room needed to be changed due to the dark brown/red stains. Housekeeper #1 could not provide a reason for why the privacy curtain was not changed earlier in the week. The Housekeeping Manager was interviewed on 3/19/26 at 9:50 AM. He revealed that housekeepers were responsible for changing out the privacy curtains upon discharge or when soiled or stained. The Housekeeping Manager stated that Housekeeper #1 could have reported the curtain issue in Resident #18's room, and he believed the dark brown/red marks were burns from the dryer. He indicated that regardless of what the marks were from, the privacy curtain should have been changed as soon as the markings were noticed. b. Resident #79's significant change MDS assessment dated 1/23/26 revealed that she was severely cognitively impaired. An observation of Resident #79's room, located on the 200 hall, on 3/17/26 at 9:15 AM revealed the oxygen concentrator had visible white particles all over the top surface. An additional observation was conducted on 3/19/26 at 8:35 AM revealed the oxygen concentrator in Resident #79's room had visible white particles all over the top surface. Housekeeper #2 was interviewed on 3/19/26 at 9:38 AM. She revealed that it was the housekeeper's responsibility for wiping down the oxygen concentrators in resident rooms.	F0584	Continued from page 3 The Housekeeping Manager with oversite of the Administrator will audit 10% of resident rooms to include resident #18, resident #79 and resident #160 weekly x 4 weeks then monthly x 1 month. This audit is to ensure cleanliness of privacy curtains, oxygen concentrators and other equipment surfaces, walls around beds and high-contact areas and to maintain a safe and homelike environment. The Housekeeping Manager will address any concerns identified. The Administrator will review the room audits weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The Administrator will present the findings of the room audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review and to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of Compliance: April 7th, 2026	

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F0584 SS = B	Continued from page 4 An observation in Resident #79's room was conducted during an interview with Housekeeper #2 on 3/19/26 at 9:45 AM. Housekeeper #2 confirmed that it was her responsibility to clean the oxygen concentrator in Resident #79's room. She stated that she did not notice that the concentrator needed to be cleaned prior to 3/19/26. Housekeeper #2 could not provide a reason why it was not cleaned earlier in the week. The Housekeeping Manager was interviewed on 3/19/26 at 9:53 AM. He revealed that the oxygen concentrators were supposed to be cleaned on a weekly basis, usually on Wednesdays, along with any other medical equipment in resident rooms. He indicated the oxygen concentrators should also be cleaned if dirty, dusty, or soiled. The Housekeeping Manager stated the oxygen concentrator in Resident #79's room should have been cleaned on Wednesday 3/18/26 by Housekeeper #2. c. Resident #160's quarterly MDS assessment dated 12/31/25 revealed that he was severely cognitively impaired. An observation of Resident #160's room, located on the 200 hall, was conducted during an interview with Nurse Aide #2 on 3/16/26 at 2:19 PM. Resident #160 was lying in bed with his left knee bent and resting on the wall to the left of the window. Dark red marks that resembled a dripping pattern were observed on the wall where Resident #160's left knee was touching. Nurse Aide #2 stated that the drippings were in fact blood and displayed Resident #160's knee with 3 scabbed areas. Nurse Aide #2 further stated that the wall had not been cleaned since she started at the facility 2 weeks ago. She then went and retrieved a clean pillow and placed it in between Resident #160's knee and the wall. Housekeeper #2 was interviewed on 3/19/26 at 9:38 AM. She revealed that she did not notice the dark red marks on the wall in Resident #160's room prior to 3/18/26. Housekeeper #2 stated she noticed the dark red marks on the wall in Resident #160's room on 3/18/26 and cleaned the wall at that time. She added that if anything needed to be cleaned out of the ordinary, the Nurse Aides were supposed notify housekeeping. During a follow-up interview with Nurse Aide #2 on	F0584		

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F0584 SS = B	Continued from page 5 3/19/26 at 3:41 PM, she revealed that she could not provide a reason why she did not notify housekeeping about the blood stains on Resident #160's wall. She stated, "I just did not think about it." The Housekeeping Manager was interviewed on 3/19/26 at 9:52 AM. He revealed that when rooms were cleaned daily, housekeeping was expected to focus on wiping down all "vertical and horizontal" surfaces including walls. The Housekeeping Manager stated that Housekeeper #2 should have noticed the blood stains on the wall in Resident #160's room and cleaned the wall during routine room cleaning. The Administrator was interviewed on 3/19/26 at 1:18 PM. He revealed that perhaps the cleaning process was not outlined by the Housekeeping Manager with housekeeping staff, or they were rushing through their work. The Administrator indicated that the privacy curtain in Resident #18's room was replaced, the oxygen concentrator in Resident #79's room should have been cleaned, and the wall in Resident #160's room cleaned. He stated that these tasks should have been completed in a "timely manner." The Administrator did not explain what specific period of time equated to a "timely manner."	F0584		
F0641 SS = A	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F0641		04/07/2026

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F0641 SS = A	Continued from page 6 §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment and the area of discharge status for 1 of 3 residents reviewed for discharge (Resident #177). Findings included: Resident #177 was admitted to the facility on 1/27/26. A Social Work (SW) progress note for Resident #177 dated 1/27/26 at 4:13 PM written by SW #1 revealed Resident #177's Responsible Party (RP) expressed the desire to take Resident #177 back home. The Against Medical Advice (AMA) process was explained to the RP who signed the AMA paperwork for Resident #177. SW #1 was unavailable for interview. A Release of Responsibility for Discharge form for Resident #177 dated 1/27/26 at 3:24 PM signed by Resident #177's RP revealed Resident #177 was being discharged from the facility against the advice of Resident #177's attending physician and the facility administration. A review of Resident #177's discharge Minimum Data Set (MDS) assessment dated 1/27/26 revealed her discharge was unplanned to a short-term general hospital. In an interview on 3/18/26 at 8:46 AM MDS Nurse #1 stated she coded Resident #177's discharge MDS assessment dated 1/27/26 to reflect Resident #177's unplanned discharge. She stated her coding that Resident #177 was discharged to a short-term general hospital was an error. She reported Resident #177 was	F0641		

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F0641 SS = A	Continued from page 7 discharged home AMA. On 3/18/26 at 2:45 PM an interview with the Director of Nursing (DON) indicated resident's MDS assessments should be coded to accurately reflect their discharge destination. On 3/19/26 at 10:57 AM an interview with the Administrator indicated resident's MDS assessments should be coded to accurately reflect their discharge destination.	F0641		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews the facility failed to label or date food items stored in 1 of 1 walk-in cooler. This had the potential to affect food served to residents. Findings included: On 3/16/26 at 10:31 AM during the initial kitchen tour an observation of the facility's walk-in cooler was conducted with the Dietary Manager. An unlabeled and	F0812	F812 Food Procurement, Store/Prepare/Serve- Sanitary 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 03/17/2026, the Dietary Manger discarded pudding and sandwiches in the walk in cooler without an "open" or "use by date". 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 04/03/2026, an audit of the walk-in refrigerators, free-standing refrigerators, and dry storage areas was completed by the Dietary Manager under the oversight of the Administrator to ensure all food items were labeled with an "open" or "use by date" and that no items were expired. The Administrator will address all concerns identified during the audit to include removing and discarding items out-of-date or not dated per facility protocol and training of staff. The audit will be completed by 04/03/2026 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 04/03/2026, the Dietary Manager initiated an in-service with all dietary staff regarding (1) Label/Dating and Expired Foods with emphasis on labeling/dating food items and discarding items per facility protocol when out of date/expired. The in-services will be completed by 04/06/2026. After 04/06/2026 any dietary staff who have not completed the in-services will complete it at the next scheduled work shift. All newly hired dietary staff will be in service during orientation.	04/07/2026

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F0812 SS = E	Continued from page 8 undated rectangular metal container covered with clear plastic wrap was observed to contain what the Dietary Manager described as being about 10 ounces of pudding. An additional unlabeled and undated rectangular metal sheet pan covered with aluminum foil was observed to contain what the Dietary Manager described as being about 20 turkey sandwiches. The Dietary Manager reported that when she left the facility at 4:00 PM on Friday 3/13/26, neither the pudding nor the sandwiches were present in the walk-in cooler. She stated they must have been prepared and placed there sometime over the weekend, but because they were not labeled or dated, she could not say for sure. She indicated she and her Assistant Dietary Manager monitored the walk-in cooler for unlabeled or undated food items during the week, but there was no one designated to do this on weekends. She reported that all food items placed in the walk in cooler should be labeled or dated. The Dietary Manager stated whoever placed a food item in the walk in cooler would have been responsible for labeling or dating it. On 3/19/26 at 10:57 AM an interview with the Administrator indicated there should be no unlabeled or undated food items in the walk-in cooler.	F0812	Continued from page 8 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator will complete kitchen observations 2 times a week x 4 weeks then monthly x 1 month utilizing the Kitchen Audit Tool. This audit is to ensure staff properly labeled/dated food with an “open” or “use by’ date when opened and expired items discard when indicated. The Administrator will address all concerns identified during the audit to include removing and discarding items out-of-date or not dated per facility protocol and re-training of staff. The Administrator will review the Kitchen Audit Tool twice weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will present the findings of the Kitchen Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 1 month for review and to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of Compliance: April 7th, 2026	