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 _____	**08/18/2016**

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 000	INITIAL COMMENTS A Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. The facility is utilizing speical locking systems. In the exit conference all deficiencies noted were discussed and acknowledged with administration. Stories: One Construction Type: V (111) Constructed: 1974 Fully Sprinkled - Yes At time of survey the: Total Certified Bed Count = 200 Census = 186 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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: 42 CFR 483.70 (a) Based on observations, and documentation review on 8/18/2016, at approximately 9:45 AM	K 029	K029 The door to the soiled utility room on station two was repaired with new closure	9/29/16

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

Electronically Signed | 09/02/2016

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 029	Continued From page 1 onward, the following deficiencies were noted: The facility maintenance and inspection of egress corridor doors was non-compliant, specific findings include: The door to the soiled linen rom near the nurses station number two is equipped with a door closure. The door closer when activated does not close the door tight in its frame. This deficiency affects 1 of approximately 12 smoke zones in the facility. Ref: 2000 NFPA 101 Section 19.3.6.3.2* Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke	K 029	and repair to frame/plate to ensure a tight closure by Hillco support Services on 8/23/16. A 100% audit of all egress corridor doors was performed by the maintenance director on 8/18/16 to ensure that all egress doors in the corridors close tightly to frame. Upon completion of the audit, no other doors were found to be out of compliance. The Administrator initiated a corridor door monitoring tool on 8/29/16 for the Maintenance Director, and Assistant Maintenance to utilize to ensure exit and corridor doors remain in proper function. The Administrator educated the Maintenance Director, and Assistant Maintenance on monitoring tool on 8/29/16 and that in any event that a corridor door is not properly functioning and closing tightly the administrator is to be notified immediately. The Maintenance Director, and/or Assistant Maintenance will conduct the door checks utilizing the monitoring tool weekly for 4 weeks, then monthly for 12 months. The Maintenance Director, and/or Assistant Maintenance will report monthly the results of the audits to the Quality Assurance Performance Improvement Committee. This committee will review the audits and recommend continued monitoring as necessary.	