| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345113 | A. Building<br>B. Wing | 03/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Willow Creek Nursing and Rehabilitation Center | 2401 Wayne Memorial Drive<br>Goldsboro, NC 27534 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>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 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. |

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.

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

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| F 0584<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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. 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 [DATE] 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. 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 [DATE] 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<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | 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 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. |