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
	345050	A. BUILDING _____ B. WING _____	05/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACOB'S CREEK NURSING AND REHABILITATION CENTER	1721 BALD HILL LOOP MADISON, NC 27025

(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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	Jacob's Creek Healthcare and Rehabilitation acknowledges receipt of the Statement of Deficiencies and purposes 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 the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob's Creek's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Jacob's Creek reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding. F 156 System was changed at time of survey which allowed AR bookkeeper an effective manner in which to ensure that two day notices are sent out as per regulation. Under the changed system, the AR bookkeeper will be notified by the MDS office of any Medicare discontinuations. At that time she is going to explain to residents, providing the letters and/or sending out letters.	6/24/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tonya Q. Dix

TITLE: Admin

(X6) DATE: 6/20/11

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 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This	F 156	Medicare residents are discussed Monday – Friday in morning Medicare Meeting and all discontinuations will be communicated at that time. The field accountant assigned to our facility from our corporate office conducted extensive training with AR bookkeeper and her assistant in our facility 5/31/2011 – 6/2/2011. The regulation was reviewed with both employees as well as the company's expectation for compliance. A QI tool was implemented and administrator will monitor that notices are sent out timely per regulation weekly X4 weeks and monthly thereafter. Any issues will be addressed immediately with bookkeeping and corporate field accounting staff. Audits of the notices will be reviewed quarterly at the Executive Committee meeting.	

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F 156	Continued From page 2 includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility did not provide a minimum two days notice for 3 of 5 sampled residents (Residents # 121, #204 and #76) denied benefits for Medicare skilled services. The findings include: 1. On 5/27/11 a record review was conducted which revealed that on 1/8/11, Resident #121 was admitted into the facility. On 1/21/11, a phone call was made by the Business Office Manager to the Power of Attorney (POA), who was infomed that on 1/21/11, Resident #121 ' s Medicare benefits would end since the resident had returned to a base line level of care. The Business Officer Manager followed up the phone call by sending the POA a certified letter on 1/21/11, notifying her of the change of Medicare coverage. It was	F 156		

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F 156	Continued From page 3 received by the POA on 1/25/11. On 5/27/11 at 11:00am, the Business Office Manager was interviewed. She stated that she was aware that she should allow 48 hours advance notice before Medicare benefits are denied. 2. On 5/27/11 a record review was conducted which revealed that on 2/8/11, Resident #204 was admitted into the facility. On 3/9/11, a letter was issued by the Business Office Manager to the responsible party stating that on 3/10/11, the resident would be denied Medicare benefits for nursing services since she had reached maximum rehabilitation potential and had met her goals for treatment. On 5/27/11 at 11:05am, the Business Office Manager was interviewed. She shared that she normally made a phone call or collected a signature for Medicare Non-Coverage letters 48 hours in advance. On 3/3/11, she explained that the rehabilitation department completed documentation that the resident would not be covered after 3/10/11. If she was able to determine that a resident was cognitively intact, she visited the resident the day before the coverage ended to get a signature. However, if the resident was cognitively impaired, she sent the letter to the responsible party, via certified mail, 48 hours in advance. The letter addressed to Resident #204 ' s responsible party was dated 3/9/11. 3. On 5/27/11 a record review was conducted which revealed that on 5/6/11, Resident #76 was re-admitted to the facility. On 5/26/11, a Medicare	F 156		

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F 156	Continued From page 4 Non-Coverage letter was prepared for him, due to him returning to a baseline level of care. Resident #76 signed the letter on 5/26/11. On 5/27/11 at 11:10am, the Business Office Manager was interviewed. She stated that Resident #76 was cognitively intact and still in the facility. Yesterday, she indicated that she visited him in his room in order to gain his signature on the Medicare Non-Coverage letter. However, she stated that last week, she made a visit to the resident ' s room to verbally inform him that his Medicare coverage would end on 5/26/11 but failed to document this in his record.	F 156		
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 observation, staff interview and facility document review the facility failed to provide thorough incontinent care for 1 of 3 dependent residents (Resident #218). Findings include: Resident # 218 was admitted to the facility on 1/4/11 with diagnoses that included right sided hemipelegia, cerebral vascular disease and hypertension. Review of the Quarterly Minimum Data Set (MDS) dated 4/27/11 revealed Resident	F 312	F 312 Resident #218 continues to be provided thorough incontinent care. Staff member #6 received one-on-one retraining regarding incontinence care at the time of survey. All NAs will be inserviced regarding thorough incontinent care by 6/24/2011. Administrator and SDC conducted retraining.	6/24/11

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F 312	Continued From page 5 # 218 had cognitive impairment. She required extensive assistance of two people for bed mobility and personal hygiene and was incontinent of bowel and bladder. Review of the care plan for Resident # 218 dated 1/11/11 revealed the following focus area " At risk for UTI (Urinary Tract Infection) R/T (related to) incontinence ", under interventions it read " Provide appropriate perineal care. " Review of 3 in-service training forms titled " Complete In-Service Training Report with Staff Attending " revealed the facility provided in-service to NA staff on 9/27/10 regarding " Infection Control - Reducing the number of UTI ' s. " The forms revealed that staff were provided a handout at the inservice " Handouts on perineal care for the female and male residents. " Review of the attached handout revealed, in part " For a female resident: Wash the perineum with soap and water. Move from front to back. Use single strokes. " " Do not wash from the back to the front. This may cause infection. Use a clean area of the washcloth or clean washcloth for each stroke. First wipe the center of the perineum, then each side. Spread the labia majora, the outside folds of perineal skin that protect the urinary meatus. " " Wipe from front to back on each side. " On 5/17/11 at 5:15 AM Nursing Assistant (NA) # 6 was observed providing incontinent care to Resident #218. The resident had been incontinent of bladder. Once the resident ' s briefs were removed the NA kept the resident positioned on her right side with her legs slightly bent. The NA used cleansing wipes to clean the	F 312	Resident care audits (QI form implemented for documentation) will be completed by administrative nursing team (which is comprised of DON, ADON, QI Nurse, MDS Nurses and SDC) weekly to include thorough and complete incontinent care at random throughout the facility on all three shifts. A minimum of 12 resident care audits will be completed weekly with a minimum of 1/3 of these audits being off shift and weekends. The results of these audits will be forwarded to DON/ADON weekly upon completion for follow up. Audits will be completed weekly X90 days and a minimum 10 audits will continue monthly thereafter on-going. Any areas of non-compliance will result in appropriate disciplinary action or retraining as appropriate. A summary of resident care audits completed and any issues related to ADL care will be reported to the Executive Committee Quarterly by the ADON.	

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F 312	Continued From page 6 resident ' s buttocks area in a front to back motion. She used a fresh wipe for each cleansing motion and started in the midline of the buttocks and moved outward. NA # 6 then rolled the resident onto her back. Resident #218 was lying on her back with her legs approximately shoulder width apart and her upper thighs touching. NA #6 used a fresh wipe to cleanse the resident ' s mons pubis in a front to back motion. The NA then applied a clean brief on the resident. The resident ' s perineum was not cleansed and the NA did not position the resident ' s legs to facilitate cleansing of the perineum. On 5/28/11 at 11:00 AM NA #6 was interviewed about the incontinent care she provided to Resident #218 on 5/17/11 at 5:15 AM. She indicated that she felt that she gave good incontinent care. When asked what she had been taught in terms of how to cleanse the perineum of a female resident she revealed that she was taught to start in the center in a front to back motion and to then cleanse on each side in a front to back motion. When asked if she had moved the resident ' s legs apart so she could cleanse the resident ' s perineum as she had described, she indicated that she had not done this but had given the resident good care. When asked what can occur when pericare is not given properly NA #6 stated " UTI " . In interview with the Assistant Director of Nursing on 5/28/11 at 11:30 she indicated that nursing staff are expected to include cleansing of the perineum when providing incontinent care.	F 312		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 7 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility policy review, facility staff failed to safely transfer a resident using a mechanical lift for 1 of 4 residents (Resident # 16) as well as failed to eliminate splinters from wooden handrails on 4 of 6 hallways. Findings include: Review of the Policy titled " Safe Resident Handling and Movement Policy " provided by the Administrator and dated " Nursing Policy Manual (Version 4/2007) (revised 5/26/09) revealed, in part " Staff will follow the movement and handling procedures for each resident as individually determined through the admission/re-entry admission process and the RAI (Resident Assessment Instrument/Minimum Data Set assessment) process." The policy further revealed " All employees are required to follow the movement and handling procedures for each individual resident as specified on their Resident Care Guide and on the Lift Signage in the resident ' s room. " 1. Resident # 218 was admitted to the facility on 1/4/11 with diagnoses that included right sided	F 323	F 323 Facility is transferring resident # 16 safely using mechanical lift and 2 person assist. Care plan and care guide were implemented by ADON. Splintered hand rails were repaired on all hallways. All residents who require use of mechanical lift were reviewed by ADON for safe transfer plan of care. Changes were made in plan of care as identified. Residents were assessed for sense of security during lift process through this process. Nursing staff have been instructed through inservicing if any resident becomes scared or initiates unsafe movements that the transfer is to be stopped immediately and the charge notified for assistance. ADON is to be notified at that time to reassess resident for appropriate transfer assistance. A building wide audit was completed by Maintenance Director; all issues related to hand rails were corrected at the time of audit. All Nursing Staff will be inserviced by 6/24/2010 regarding proper lift usage per plan of care to include interventions if	6/24/11

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F 323	Continued From page 8 hemipelegia, cerebral vascular accident and seizure disorder. Review of the Quarterly Minimum Data Set (MDS) dated 4/27/11 revealed Resident # 218 had moderate cognitive impairment. She required extensive assistance of one staff member for bed mobility, dressing and personal hygiene and extensive assistance of two people for transfers. On 5/25/11 at 11:52 AM Resident #16 was observed sitting in her wheelchair. She had a large dark purple bruise surrounding her right eye with a varying width of up to approximately 2 inches and a swollen round purple bruise approximately 1 inch in diameter above her right eyebrow. The resident stated she got the bruise when she was being transferred and the bar banged her in the eye. Review of the Care Plan for Resident #16 revealed the following focus area initiated on and created on 3/16/11 " Requires assistance/potential to restore or maintain function of self-sufficiency for TRANSFERRING from one position to another related to phys (physical) limitations. " The goal for this area initiated and created on 3/16/11 was "Will receive the necessary physical assistance to transfer thru (through) next review." The interventions listed were: "Mechanical Lift: Viking Lift ", initiated and created on 3/16/11. "Use Mechanical lift with padded bar when transferring to prevent injury", initiated and created on 5/26/11. "TRANSFERS: Provide two person constant guidance and physical assist during mechanical lift transfers", initiated and created on 3/16/11,	F 323	residents become scared or unsafe in movements. Proper life usage was inserviced to include the proper procedure for lift usage as well as the staff responsibility of getting the nurse if the resident becomes anxious or agitated with unsafe movements during transfer. Inserviceing was completed by Administrator and SDC for all nursing staff. The ADON will update the care plan and care guide with any necessary changes in lift plan of care through review of incidents and nursing reports as incidents occur. Maintenance was re-trained by administrator regarding hand rail maintenance to include that no splintering can be present to hand rails. Facility is in process of changing out wooden hand rails to vinyl ones that will not splinter. Resident care audits (QI tool implemented) will be completed weekly by administrative nurses randomly throughout facility on all three shifts. A minimum of 12 resident care audits will be completed weekly with a minimum of 1/3 of these audits being off shift and weekends. Transfers via mechanical lift will be audited at this time. The results of these audits will be forwarded to DON/ADON for follow up. Audits will continue weekly for 90 days and monthly on-going thereafter.	

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F 323	Continued From page 9 ADON (Assistant Director of Nursing) revision on 5/25/11. Review of the medical record revealed a Progress Note dated 3/16/11 that read " res (resident) states cannot stand/pivot will req (require) Viking lift (mechanical lift brand name)." There was no note indicating whether one or two staff would be needed to transfer the resident when using the Viking lift. According to the 3/21/11 MDS, Resident #16 required extensive assistance of two people for transfers. During an interview with Nursing Assistant (NA) #5 on 5/27/11 at 5:45 PM she stated that she had only worked with Resident #16 a few times but each time she transferred the resident with the Viking lift she got a second person to help her. NA #5 further explained that although the Resident Care Guide had listed Resident #16 as requiring one person to transfer " I got the nurse to help me the first time because of the fear that was in (name of resident), I wanted to make her feel safe " . NA #5 also said that every time she transferred Resident #16 she got a second person to help her because the resident would get scared and was afraid of falling. NA #5 denied an incident where the resident was almost dropped in the lift but said that as the lift brings the resident up off the bed the lift pad slips down around the person more and that may have been the sensation that made Resident #16 feel like she was being dropped and that made her afraid of falling. When asked if she reported to anyone that the resident seemed less fearful with a two person rather than a one person Viking lift transfer NA #5 stated that she reported this to the ADON on 5/25/11 and indicated that she had not	F 323	Monthly Environmental QI rounds using a rounds tool will be completed by Administrator or Designee with issues related to wooden handrails reported to maintenance department for timely correction. Any concerns noted by facility or administrative staff during rounds will be reported to maintenance through the work order process. Any areas of non-compliance will result in appropriate disciplinary action or retraining as appropriate. Transfer related resident care audits will be reviewed by ADON bi-weekly and reported to executive committee quarterly. Safety committee will monitor for hand rail safety monthly during safety committee rounds. All issues will be reported to administrator for appropriate follow-up and intervention.	

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F 323	Continued From page 10 reported it prior to that. Review of the Assignment Sheet from 5/17/11-5/20/11 revealed NA #5 had been assigned to wok with Resident #16 on 5/17/11 and 5/18/11 on 3 PM - 11 PM shift. Review of the Incident Report dated 5/20/11 at 1640 (4:40 PM) revealed the following items were checked off "hematoma", "mechanical lift", "head", "frontal", "totally dependent", "resident's room" . In addition, the following items were checked as " No": "other employees present (No)", "other resident's present (No)", "visitor present (No)". A handwritten description of the incident signed by Nurse #2 read "CNA (Nursing Assistant) stated, she (Resident #16) became upset and frightened while lifting her." A handwritten description of the incident signed by NA #4 read "She (Resident #16) was being picked up by the lift. She got real frightened and she started to move around and pull on the lift bar. She kept saying (name of NA #5) almost dropped her the day before and was afraid it would happen again. She said (name of NA #5) made her afraid of the lift and she didn't want to be in it." A Progress Note dated "Late Entry" 5/20/11 at 22:43 (10:43 PM) read, in part "CNA (Nursing Assistant) reported to this nurse that resident became anxious while being transferred by lift. Resident grabbed a hold of the bar in front o her and the bar hit the resident in the frontal side of the head. Ice was applied to forehead for 20 min (minutes) on and off through the shift. Neurological checks started on resident per protocol. No s/s (signs/symptoms) of distress.	F 323		

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F 323	Continued From page 11 VS's (vital signs) were taken and were WNL (within normal limits). Pupils are equal and reactive. Hand grasp bilaterally are equal. Moves all extremities. Resident is concerned that a bruise will appear and she has a wedding rehearsal tomorrow. Called RP (Responsible Person) (name of RP) and was notified of injury. (RP) stated that the resident had been acting anxious on occasion for the past few days when it came to being in the lift. Resident stated to nurse that a CNA had almost dropped her a few days previously while using the lift. Resident did state that CNA did have help" Interview with Nurse #2 on 5/26/11 at 5:30 PM revealed she did not see the incident on 5/20/11. Nurse #2 stated that NA #4 told her that while lowering Resident #16 into the wheelchair, with the lift, Resident #16 started to scream and yell and the bar hit the resident in the head. Nurse #2 stated she applied ice packs to the hematoma and initiated neurological checks per facility protocol which was every 15 minutes for the first hour, then every 30 minutes for an hour and then every hour for the remainder of 24 hours. She indicated that there were no adverse outcomes noted as a result of the neurological checks. Nurse #2 indicated that she also notified the RP and told him Resident #16 had gotten scared and anxious on the lift. She further revealed that the RP said she had been like that lately and Nurse #2 said she thought it could have been in part because Resident #16 had just transferred to 100 hall a few days before the incident and didn't know the staff on 100 hall yet. During an interview with NA #4 on 5/26/11 at 5:45	F 323		

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F 323	Continued From page 12 PM she stated that before transferring Resident #16 on 5/20/11 she checked the Resident Care Guide in the closet to see if she was a 1 person or 2 person transfers with the Viking lift. NA #4 revealed that the Resident Care Guide listed Resident #16 as a 1 person Viking lift transfer at that time. NA #4 said that on 5/20/11 when she lifted the resident up with the Viking lift she was fine but on the way down she got scared, grabbed the bar and started yelling. NA #4 also said that after the incident she suggested that the resident be transferred with two people. Review of the form titled "Investigation Follow-up" dated 5/20/11 (no time) revealed: " Description of Event/Incident", "Resident was being transferred with Viking lift, when lifted resident became frightened pulling on the lift bar. Lift bar hit resident in forehead. Greenish bruise noted on forehead." Contributing Factors", " Mechanical lift." "Interventions Taken to Prevent Reoccurrence ", Pad lift bar on Viking lift, neuro (neurological) checks, two people to transfer resident with Viking lift." Interview with the ADON on 5/27/11 at 6:15 AM revealed that the Investigation Follow-up with a recommendation for a 2 person mechanical lift transfer was completed on the day of the incident, 5/20/11. However, the Care Plan was not updated with this requirement to use two people when transferring Resident #16 with the Mechanical lift until the 5/25/11. Interview with the ADON on 5/27/11 at 6:15 AM also revealed that she talked to NA #5 about Resident #16 on 5/25/11 and NA #5 told her at that time that she thought Resident #16 would be less fearful of being transferred if two people	F 323		

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F 323	Continued From page 13 transferred her with the Viking lift. She further indicated that it would have been better if NA #5 had reported this prior to the incident on 5/20/11. Interview with the QI Nurse on 5/27/11 at 6:17 AM revealed that she updated the " Resident Care Guide " for Resident #16 on 5/26/11. She further explained that on 5/26/11 she updated the " Resident Care Guide " kept inside the closet of Resident #16 by scratching out the check mark for transferring with the aid of 1 person and checking off the aid of 2 person box. The QI Nurse also stated that she wrote in the statements under additional information about " use 2 people when transfer with mechanical lit. Use lift with padded lift bar to prevent injury " on 5/26/11. On 5/26/11 review of the form titled " Resident Care Guide " for Resident #16 (no date) revealed, in part under " Handling/Movement " " Aid of 1 Person " had been checked off and crossed out and " Aid of 2 Persons " was checked off. "Viking Lift" "Sling M (medium) was also checked off. " Under the "Additional Information" heading the following was handwritten " use 2 people when transfer with mechanical lift. Use lift with padded bar to prevent injury. " On 5/28/11 at 11:30 AM the Resident was observed being transferred from the bed to the wheelchair in the Viking lift. Two unidentified NA staff transferred the resident and a third came to assist as well and held the wheelchair. Resident #16 remained calm during the transfer with her arms safely crossed in front of her as one of the NA ' s had reminded her to do. The resident was	F 323		

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F 323	Continued From page 14 transferred from the bed to the wheelchair without incident. The Viking lift that was used for the transfer was not padded. 2. On 5/23/2011 a tour was conducted on the hallways in the facility. The 400 hallway handrails were being replaced with vinyl handrails but approximately 75% of the handrails on this corridor remained wooden. The handrails on 100, 400, and 600 hallways had jagged pieces of wood and were worn lacking varnish on some of the equipment. These handrails were rough and contained splinters. There were several residents seen in the hallways using the handrails to propel themselves. On 5/26/2011, an interview at 9:30am was conducted with the Maintenance Assistant. He stated they do not have a schedule to check the handrails in the building. He voiced they are dependent on the staff to bring concerns to their attention. On 5/27/2011 at 10:00am, accompanied by the Maintenance Supervisor an environmental tour was conducted in the facility. The handrails were rough and had deep cuts into the wood with splintering at the following areas: * A wooden handrail in the lobby under the resident directory sign * On the 100 hall outside of the resident shower door * Outside the soiled utility biohazard door * Between the doors of rooms 120 and 122 * On the 100 hall, outside of the restorative dining	F 323		

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F 323	Continued From page 15 room doors * Under the 100 hall information board * Outside room 206 on both sides * Outside the resident shower room on 300 hall * Outside room 300 *The remaining wooden handrails on the 400 hall. The Maintenance Supervisor stated he has limited staff and they were doing many of the renovations in other areas in the building. He shared that they prioritized maintenance duties to urgent repair work and depend on staff to bring general concerns to their attention. The Maintenance Supervisor reported they work on filing down the rough spots on the handrails every week where residents hit them with their wheelchairs. He said that eventually all the handrails would be replaced with the more sturdy vinyl handrails like those on the 500 hall and part of the 400 hall. The Maintenance Supervisor said he did not have a set date for completion of replacing the wooden handrails nor did he have the needed supplies for completion. He said he thought the wooden handrails were too rough and splintered for patient safety and that he and his assistant would get to work on filing down the rough spots right away.	F 323		
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	F 371	F 371 Refrigerator Repair Company visited at the time of survey and made repairs to walk in. Temperatures were audited throughout the remaining days of the survey and remained within range. A lock box was placed over the air conditioning controls to keep staff from changing environmental temperatures	6/24/11

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F 371	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility document and policy review the facility failed to monitor refrigerator temperatures over 41 degrees to be sure foods continued to be stored at safe temperatures. Findings: Review of the policy titled " Purchasing and Storage " dated " Dietary Policy Manual (Rev. 9/2006) " revealed, in part " Frozen foods are to be accepted at proper temperatures of 0° or below and refrigerator foods at 41° or below (if a temperature other than 41° is specified, the food may be received at that temperature). Potentially hazardous foods will be maintained at safe temperatures until used. " On initial tour of the kitchen on 5/23/11 at 8:30 PM the thermometer on the front of the walk in refrigerator above the door read 46 degrees. Interview with the Dietary Manager on 5/23/11 at 8:31 PM revealed dietary staff do not use that thermometer as it is broken. She stated that they use the thermometers inside the refrigerator. Observation of the thermometers inside the refrigerator revealed 3 thermometers clustered on the second from the top shelf of the walk in refrigerator approximately three quarters of the way into the refrigerator. Two to the three thermometers read 48 degrees and the third read	F 371	In-servicing was completed with all dietary staff regarding safe refrigerator temperatures and the appropriate steps to take if refrigerator is not within appropriate temperature range. Staff was retrained to keep refrigerator door closed as much as possible if temperatures are not within range and re-check temperature in one hour. If temperature is still not within appropriate range maintenance is to be contacted. A Temperature Log Procedure was posted on both walk in cooler and freezer in the kitchen to communicate proper procedure to staff routinely. Temperatures will continue to be checked on all walk in coolers and freezers q shift using the internal thermometer, with results logged on temperature log. If re-check is required this will also be documented on the temperature log. Kitchen Manager or Assistant Manager will review temperature logs daily Monday - Friday to ensure that temperatures are remaining within range and appropriate intervention is taking place if out of range temperatures are identified. Maintenance department will continue to check refrigerator temperatures and freezers 3-5 times per week using the laser thermometer; this will be documented on the preventative maintenance sheet for the cooler/freezer. Any issues will be corrected immediately.	

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F 371	Continued From page 17 46 degrees. There was condensation observed on the lids of the plastic containers of food items such as pimento cheese spread dated 5/23/11. Review of the " Temperature Chart for Refrigerators and Freezers " located on the front door of the refrigerator revealed the PM temperature for 5/23/11 was 44 degrees. Interview with the Dietary Manager at 8:35 PM revealed that the refrigerator had not been opened recently and she would have expected the temperature to be about 40 degrees. Observation of the walk-in refrigerator on 5/24/11 at 9:20 AM revealed two of the internal thermometers registered 48 degrees and one registered 44 degrees. The Dietary Manager confirmed these temperature observations. Review of the " Temperature Chart for Refrigerators and Freezers " located on the front door of the refrigerator revealed the AM temperature for 5/24/11 was blank. At the bottom of the form it read, in part: " Temperature Ranges: CCL: Refrigerators - 35 °F (degrees Fahrenheit) - 41 °F " , " Corrective Action: 1) If temperature registers above CCL, immediately notify maintenance department; notify manager. 2) Retake temperature in 1 hour. If temperature again registers above CCL, initiate product removal/relocation procedure. " There were also two other recorded temperatures above 41 degrees recorded for May 2011. These were 44 degrees on 5/11/11 in the PM and 44 degrees on 5/12/11 in the PM. Interview with the Dietary Manager at on 5/24/11	F 371	Administrator or designee will monitor temperature documentation weekly for 90 days and as needed thereafter. Any issues of non-compliance will result in immediate retraining or disciplinary action as appropriate.	

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F 371	Continued From page 18 at 9:30 AM revealed that staff use the " Temperature Chart for Refrigerators and Freezers " to record the temperature in the morning and again in the evening. She acknowledged that the AM temperature for 5/24/11 had not been recorded and that after the observed temperature of 48 degrees on 5/23/11 at 8:30 PM a subsequent temperature within an hour had not been taken or recorded. On 5/25/11 at 5 PM observation of the walk in refrigerator temperature revealed there was one thermometer in the refrigerator on the second from the top shelf approximately three quarters of the way into the refrigerator. The thermometer registered 38 degrees. The temperature of the pimento cheese spread dated 5/23/11 was measured and was 41 degrees. On 5/25/11 at 5:10 PM during an interview with the Dietary Manager she acknowledged no food had been discarded based on the observed temperatures of 48 degrees on 5/23/11 at 8:30PM and 48 degrees on 5/24/11 at 9:20 AM. Follow-up temperatures were not taken on 5/23/11. Review of follow-up temperatures taken on 5/24/11 revealed: 10:33 AM 44 degrees 1113 AM 39 degrees 12:30 AM 40 degrees 1:45 PM 40 degrees 2:48 PM 40 degrees 4:00 PM 40 degrees 5:30 PM 38 degrees On 5/27/11 at 10:20 AM the Maintenance Director (MD) was interviewed. He stated that he or	F 371		

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F 371	Continued From page 19 another maintenance person checks the refrigerator temperature every morning and that he had checked it on the morning of 5/24/11 at about 6:45 AM and it was fine. The MD stated that he had not recorded the temperature of the refrigerator on 5/24/11 and never has recorded the refrigerator temperature when he has checked it. The MD further noted that room temperature could affect refrigerator temperatures and stated that on 5/25/11 it was brought to his attention that it was warm in the kitchen. He checked the air conditioning unit and discovered it was not operating but was able to fix it by replacing a glass bulb in the thermostat on 5/25/11. The MD also said that he had a refrigerator service company come and check the walk in refrigerator and Freon on 5/27/11 and there were no problems identified. On 5/27/11 at 10:35 AM interview with Maintenance Technician #1 revealed that when he checked the walk in refrigerator temperature in the morning he used the thermometer above the door. He also stated that he did not record these temperatures. Interview with Dietary Aide #1 (DA #1) revealed that if the walk-in refrigerator temperature was not within the 32 - 40 degree range she would inform the Dietary Manager. She reviewed the " Temperature Chart for Refrigerators and Freezers " for May 2011 and saw that on one occasion, 5/11/11 PM, she recorded a temperature of 44 degrees. She then stated " I probably wouldn ' t call at 44, I would probably call at 48 because most of the time when the temperature is up it ' s because we ' re going in and out. " She also stated that when she	F 371		

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F 371	Continued From page 20 checked the PM temperature she usually checked it at about 8 PM and if it needed rechecking she would do it at 8:30 PM. She indicated that she did not document a follow-up temperature on 5/11/11. DA #1 said that when she checks the refrigerator temperature she uses the thermometer outside the walk-in refrigerator, above the door as that was the one she was taught to use. She was unaware that there had been 3 thermometers inside the refrigerator. DA #1 also did not know how long food could safely be stored at temperatures above 41 degrees and below 135 degrees. Review of the " Temperature Chart for Refrigerators and Freezers " from November 2010 - May 2011 revealed the following temperatures above 41 degrees: 42 degrees on 1/1/11 PM 42 degrees on 1/14/11 PM 43 degrees on 1/17/11 PM 42 degrees on 1/19/11 PM 42 degrees on 1/20/11 PM 48 degrees on 2/3/11 PM 44 degrees on 5/23/11 Temperature logs showing follow-up monitoring for the above refrigerator temperatures were requested but were not available. Further review of the "Temperature Chart for Refrigerators and Frezers "revealed there were also missing temperature recordings on 3/16/11 PM and 3/17/11 PM.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		

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F 431	Continued From page 21 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, pharmacist interview, record review, facility document review and policy review, the facility failed to initiate corrective action for low temperature readings in	F 431	F 431 All meds were removed from the 500/600 refrigerator and placed in Station 2 Med room at time of survey. 500/600 refrigerator has now been replaced. Pharmacy was contacted regarding incorrect labeling and this medication was replaced with medication with correct labeling on 5/28/2011. All residents with a current order for Lactulose were audited and clarification orders written by 6/24/2010. Pharmacist audited each resident's MAR June 2-9, 2011 and confirmed that all dosage conversions were listed correctly. Licensed nursing staff will be inserviced by Administrator and SDC on appropriate refrigerator temperatures for medication storage and steps to take if temperatures are not in appropriate range by 6/24/2011. Pharmacy Director of Clinical Services reviewed the importance of accurate MARs with the consultant pharmacist on 5/31/2011.	6/24/11

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F 431	Continued From page 22 1 of 3 medication refrigerators (500/600 hall medication room). Additionally, a medication was incorrectly labeled for 1 of 10 residents (Resident #90) reviewed for unnecessary medications. The findings included: 1. An undated policy entitled "Storage of Refrigerated Medications" read in part, "The temperature of all refrigerators containing medications shall be maintained at between 36 degree F (Fahrenheit) to 46 degree F." Observation on 5/28/11 at 11:08 AM revealed that the thermometer in the medication refrigerator in the 500/600 hall medication storage room read 33 degrees F. A form entitled "Temperature Chart for Refrigerators and Freezers" was posted on the refrigerator door. The form was dated for May 2011. Refrigerator temperatures were recorded for 5/1/11-5/4/11, 5/6/11-5/13/11, and 5/16/11-5/28/11. The recorded temperatures ranged from 20 degrees F to 38 degrees F. On only 3 dates did the recorded temperatures fall within the 36-46 degree F range: 5/6/11 - 37 degrees F, 5/7/11 - 38 degrees F and 5/28/11 - 38 degrees F. The remaining dates showed temperatures 34 degrees F and lower. The form included instructions for corrective action only if the temperature was above range. Review of the "Temperature Chart for Refrigerators and Freezers" for April for the 500/600 hall medication refrigerator revealed that temperatures had been recorded on 26 days. The temperatures ranged from 19 degrees F to 40 degrees F. On 5 days the temperatures were within the 36-46 degree range; the remaining	F 431	All medication room refrigerators are checked daily for appropriate temperature by nursing staff. This is logged on temperature log which is kept on the medication room refrigerator. The allowable temperature range is 36 – 46 degrees. If temperatures are noted to be out of range the licensed nursing staff is expected to adjust the refrigerator and re-check within one hour documenting this re-check on the temperature log. If the medication refrigerator is still not within acceptable range maintenance is to be notified and the medications in the refrigerator are to be moved to a properly functioning refrigerator. Each Licensed Nurse or Med Aide is responsible for monitoring the refrigerator of their assigned unit. Pharmacy Director of Clinical Services will review the new monthly MARS prior to delivery to the facility monthly for three months to verify that conversions are listed correctly. Findings will be reported by the pharmacist to the Executive Committee quarterly. The Executive committee will determine the	

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	345050	A. BUILDING _____ B. WING _____	05/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACOB'S CREEK NURSING AND REHABILITATION CENTER	1721 BALD HILL LOOP MADISON, NC 27025

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F 431	Continued From page 23 dates were below. During an interview on 5/28/11 at 11:08 AM, nursing assistant (NA) #1 said she was responsible for checking the temperature of the medication storage refrigerator on the 500/600 hall. NA#1 indicated that if the temperature was running low she sometimes defrosted the refrigerator but took no further action. During an interview on 5/28/11 at 2:00 PM, Administrative Staff #1 indicated that if the refrigerator temperature was running low, she expected the staff member to adjust the control and recheck the temperature a little later. If the temperature was still low, then the staff member should notify the maintenance department. Administrative Staff #1 acknowledged that the Temperature Chart did not include instructions for corrective measures if the temperature was too cold. 2. Review of Resident #90's Medication Administration Record (MAR) for May 2011 read in part: "Enulose Sol (Solution) 10/Gm (grams)/15 Mix 22.5 ml (milliliters) = 30 Grams in orange juice. Take by mouth daily". Inspection of Resident #90's bottle of Enulose revealed a manufacturer label which read in part, "10 grams per 15 milliliters". A pharmacy label was affixed to the bottle that read in part, "22.5 ml=30 Grams". Review of Resident #90's physician orders revealed an order dated 4/15/2009 for Lactulose (same as Enulose) 22.5 ml daily in orange juice.	F 431	continual need for and manner of future audits based on findings. DON or designee will QI medication storage in appropriate temperatures and accurate labeling weekly X4 weeks and monthly thereafter using a QI audit tool for documentation. Any issues of non-compliance will be corrected at the time of audit. Audits of the medication storage and labeling of medications will be reviewed by the DON or ADON weekly and summary of any concerns will be submitted to the Executive Committee Quarterly.	

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F 431	Continued From page 24 Review of Resident #90's MARs revealed that the July 2009 MAR was the initial entry which read "22.5 ml = 30 Gm". Subsequent MARs read the same. During an interview on 5/28/11 at 12:45 PM, the consultant pharmacist stated that the pharmacy had entered an incorrect conversion to grams on Resident #90's Enulose order and label. The consultant pharmacist indicated that he would have expected the error to be noted and corrected prior to the medication leaving the pharmacy or during the consultant pharmacist's chart review.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	F 441 NA #2 was retrained regarding proper hand hygiene at the time of the survey. All nursing staff will be re-trained regarding proper hand hygiene by 6/24/2010. Administrator and SDC completed this training. Included in the hand hygiene re-training is appropriate use of hand washing, gloves, and hand sanitizer. Technique for each and further discussion of cross contamination issues.	6/24/11

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F 441	Continued From page 25 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview facility staff failed to remove gloves and practice hand hygiene after providing incontinent care and moving from a dirty to a clean task for 1 of 3 residents (Resident #16). Findings include: On 5/27/11 at 5:55 AM NA #2 and NA #3 washed their hands and put on gloves. After pulling the privacy curtain; NA #3 assisted NA #2 in positioning Resident #16 for incontinent care. Resident #16 had been incontinent of bowel. NA #2 cleansed the resident ' s perineal area and buttocks using cleansing wipes intended for this purpose. She disposed of soiled wipes in a garbage bag as she went. After she was finished providing incontinent care, NA #2 opened the side table drawer and placed the container of wipes in	F 441	Resident care audits (QI tool implemented) will be completed weekly by administrative nurses randomly throughout facility on all three shifts. A minimum of 12 resident care audits will be completed weekly with a minimum of 1/3 of these audits being off shift and weekends. Hand Hygiene will be audited at this time. The results of these audits will be forwarded to DON/ADON for follow up. Audits will continue weekly for 90 days and monthly on-going thereafter until hand hygiene is determined to be a resolved problem by executive committee. Nursing Staff members observed not completing hand hygiene properly will be re-trained immediately by administrative nursing staff with any continual issues of non-compliance (any additional issue after re-training) or trends being reported to DON and Infection Control Nurse for appropriate follow-up to include additional all staff retraining, return demonstrations or other such interventions. Hand Hygiene audits will be reviewed by ADON or Designee bi-weekly with any issues related to continual non-compliance reported by the ADON to the executive committee quarterly until Committee deems resolved.	

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F 441	Continued From page 26	F 441		

the drawer and then closed the drawer. NA #2 had not removed her gloves and washed her hands or used hand sanitizer prior to putting the wipes away. Wearing the same pair of gloves that she used during incontinent care, NA #2 assisted NA #3 in putting a clean brief on the resident and positioning Resident #16 in bed. NA #2 then placed the soiled positioning pad she had removed from under the resident into a laundry bag; she removed her gloves and tied the laundry bag. NA #2 placed her gloves in a garbage bag that was being held by NA #3. NA #2 had not washed her hands or used hand sanitizer after removing her gloves. NA #2 then left Resident # 16 ' s room and went down the hall to the laundry cart. She opened the lid of the laundry cart with her hands and placed the soiled linen inside. She then brought the laundry cart closer to the middle of the hall. After she finished moving the laundry cart NA #2 used hand sanitizer to cleanse her hands.

Interview with NA #2 on 5/27/11 at 6:10 AM revealed that she was aware she should have washed her hands after completing incontinent care with Resident #16, before she moved on to clean tasks. She indicated that she had been taught to perform hand hygiene after removing her gloves but didn ' t because she was nervous and forgot.

Interview with the Assistant Director of Nursing/Infection Control Practitioner (ADON/ICP) on 5/28/11 at 11:30 AM revealed she did resident care audits weekly to ensure staff were performing hand hygiene. She also indicated that nursing staff are in-serviced on hand hygiene quarterly and on a 1:1 basis as

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F 441	Continued From page 27 needed. She stated that it was her expectation that staff would remove gloves and wash their hands with soap and water or use hand sanitizer when moving from dirty to clean tasks. The ADON/ICP further indicated that when performing incontinent care she would expect nursing staff to have removed their gloves and used hand sanitizer to have been able to remain at the bedside when they moved from dirty to clean tasks during incontinent care.	F 441		

RECEIVED JUN 0 6 2011 CONSTRUCTION SECTION

PRINTED: 05/22/2011
FORM APPROVED
OMB NO. 0938-0391

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	345050	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/19/2011

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K 029 SS=D	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: A. Based on observation on 05//19/2011 the Chapel was being used for a storage room and the doors were not positive latching. 42 CFR 483.70 (a)	K 029	Jacob's Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and purposes 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 the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob's Creek's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Jacob's Creek reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding. K 029 Latching system was corrected on 5/31/2011. All items that were being stored in the Chapel were removed on 5/19/2011. This area is no longer being used for storage. The Maintenance Director and Administrator made walking rounds on 5/31/2011 throughout facility to identify any other issues with doors and storage. Issues were corrected as identified related to storage. No other fire doors were identified as issues. All staff will be inserviced regarding proper storage by 7/3/2011.	7/3/11 7/3/11 7/3/11
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 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/19/2011 the staff interviewed did not know about the master door release switch located at the nurses station. 42 CFR 483.70 (a)	K 038		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: RN LNHA (X6) DATE: 6/3/11

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 056	Continued From page 1 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: A. Based on observation on 05/19/2011 there were two sprinkler heads blocked near room 101. one by an Exit sign mentioned on 04/28/2010 and one by a surface mounted light fixture. 42 CFR 483.70 (a)	K 056	Fire doors and storage issues to be reviewed by Safety committee monthly. Issues of non-compliance will be reported to the appropriate department head and Administrator for follow-up. K 038 Master door switch training will be integrated into new employee orientation. All staff will be inserviced regarding the Master Door Release Switch by 7/3/2011. Staff Development Coordinator and Maintenance Director will perform random audits to determine that staff is aware of location and use of Master Door Release Switch. Audits will be reported to Safety Committee. Issues will be reported to Administrator for follow-up.	7/3/11 7/3/11
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/19/2011 the valves to the accelerators were not supervised nor were the valves to the pressure operated flow	K 061	K 056 Two sprinkler heads were moved on 5/26/2011 by Advanced Fire Designs. Building wide audit was completed by Maintenance Director and Advanced Fire Designs on 5/26/2011. No other issues related to sprinkler location were identified.	

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K 061	Continued From page 2 switches B. All of the above valves were in the off position. The water would flow but no alarms would begiven. C. The sprinkler contractor had reccommended the replacement of the accelerators on 04/28/2010.	K 061	Routine inspections will continue by Advanced Fire Design with findings verbally and in writing reported to Administrator as well as Corporate Support Services. Issues will be corrected timely at the time of inspections. Sprinkler Inspections will be reviewed by Safety Committee Quarterly. Any issues	
K 062 SS=F	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: A. Based on observation on 05/19/2011 the annual certification done on 04/28/2010 showed that the systems did not meet the time requirements for delivering water to the test ports and recommended flushing the systems as the test ports stopped up and the water flow stopped. Water flow times for the systems (on 04/28/2010) were 86 sec. ,90 sec. and 160 sec.)	K 062	of non-compliance will be followed up on by administrator. K 061 Advanced Fire Design came to facility during Life Safety Inspection and corrected issue A and B on 5/19/2011. Replacement of accelerators occurred on 5/26/2011 by Advanced Fire Design. Routine inspections will continue by Advanced Fire Design with findings verbally and in writing reported to Administrator as well as Corporate Support Services. Issues will be corrected timely at the time of inspections.	7/3/11
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	Sprinkler Inspections will be reviewed by Safety Committee Quarterly. Any issues of non-compliance will be followed up on by administrator. K 062 Advanced Fire Design made repairs to Sprinkler System on 5/25/2011 and 5/26/2011 to correct issue.	7/3/11

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OMB NO. 0938-0391

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K 072	Continued From page 3 This STANDARD is not met as evidenced by: A. Based on observation on 05/19/2011 there were items not in use stored in the egress corridors (lifts, night stands, tables, chairs near rooms 126,206 and out side Rehab. 42 CFR 483.70 (a)	K 072	Testing of ports was conducted on 5/25/2011 and 5/26/2011 in the presence of the county Fire Marshall and all issues had been corrected. Routine inspections will continue by Advanced Fire Design with findings verbally and in writing reported to Administrator as well as Corporate Support Services. Issues will be corrected timely at the time of inspections. Sprinkler inspections will be reviewed by Safety Committee Quarterly. Any issues of non-compliance will be followed up on by administrator. K 072 Administrator and Safety Committee Director to make facility wide rounds to identify other storage issues. Issues identified will be corrected at the time of the audit. Proper storage of items will be integrated into new orientation for staff members. All staff members will be inserviced regarding appropriate storage of items as to not block egress corridors by 7/2/2011. Storage will be monitored by Safety Committee and Safety Committee director as well as by administrative staff during daily rounding in facility. Issues of non-compliance will be corrected as identified	7/3/11 7/3/11

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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 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/19/2011 the staff interviewed did not know about the master door release switch located at the nurses station. 42 CFR 483.70 (a)	K 038	Issues of non-compliance will be reported to the appropriate department head, the Safety committee and Administrator for follow-up. K 038 Master door switch training will be integrated into new employee orientation. All staff will be inserviced regarding the Master Door Release Switch by 7/3/2011. Staff Development Coordinator and Maintenance Director will perform random audits to determine that staff is aware of location and use of Master Door Release Switch. Audits will be reported to Safety Committee. Issues will be reported to Administrator for follow-up.	7/3/11
K 059 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have water flow devices to give warning of the operation of the systems. 13-3.5.2 This STANDARD is not met as evidenced by: A. Based on observation on 05/19/2911 the valves to the pressure operated flow switches were in the off position and not supervised. 42 CFR 483.70 (a)	K 059	K 059 Pressure valves were corrected at the time of the Life Safety Inspection by Advanced Fire Design on 5/19/2011. All other flow switches were checked at this time also. Maintenance will check to ensure that all flow switches remain in the on position upon their routine facility rounds. Routine inspections will continue by Advanced Fire Design with findings verbally and in writing reported to Administrator as well as Corporate Support Services. Issues will be corrected timely at the time of inspections.	7/3/11
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/19/2011 the	K 061		

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

RN/A | 6/3/11

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.

CD

PRINTED: 05/22/2011
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
	345050	A. BUILDING 02 - BUILDING 02 B. WING _____	05/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACOB'S CREEK NURSING AND REHABILITATION CENTER	1721 BALD HILL LOOP MADISON, NC 27025

(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 061	Continued From page 1 valves to the accelerators were not supervised nor were the valves to the pressure operated flow switches B. All of the above valves were in the off position. The water would flow but no alarms would begiven. C. The sprinkler contractor had reccommended the replacement of the accelerators on 04/28/2010. 42 CFR 483.70 (a)	K 061	Sprinkler Inspections will be reviewed by Safety Committee Quarterly. Any issues of non-compliance will be followed up on by administrator. K 061 Advanced Fire Design came to facility during Life Safety Inspection and corrected issue A and B on 5/19/2011. Replacement of accelerators occurred on 5/26/2011 by Advanced Fire Design. Routine inspections will continue by Advanced Fire Design with findings verbally and in writing reported to Administrator as well as Corporate Support Services. Issues will be corrected timely at the time of inspections. Sprinkler Inspections will be reviewed by Safety Committee Quarterly. Any issues of non-compliance will be followed up on by administrator.	7/3/11