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 _____	C 03/12/2020

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
E 000	Initial Comments An unannounced recertification survey was conducted from 3/9/20 to 3/12/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#47GN11.	E 000		
F 000	INITIAL COMMENTS A recertification with complaint investigation survey was conducted from 3/9/20-3/12/20. 6 of the 6 complaint allegations were not substantiated.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		4/9/20

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

Electronically Signed | 04/02/2020

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 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to notify the physician of abnormal laboratory results for 1 of 2 (Resident #111) reviewed for pressure ulcers. The findings included: Resident #111 was admitted to the facility on 7/26/12 with diagnosis of contracture to left hand. A non-ulcer skin condition flow sheet dated 1/6/20 revealed Resident #111 had an open area to her left hand at her thumb that was excoriated with	F 580	Jacob's Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob's Creek Nursing and Rehabilitation Center's response to this Statement of	

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F 580	Continued From page 2 moderate erythema and a moderate amount of serosanguinous drainage. The flowsheet indicated there were signs of infection and a culture of the drainage was to be obtained. A record review revealed a laboratory culture report dated 1/11/20 from a wound culture of Resident #111 ' s left hand at the thumb that was collected on 1/7/20. The wound culture showed Methicillin resistant Staphylococcus aureus (MRSA). A record review revealed no documentation of the physician being notified of the wound culture results. An observation on 3/11/20 at 9:02 AM revealed an open, reddened are to Resident #111 ' s inner left hand lateral palm at the thumb. Appeared excoriated. An interview with the Treatment Nurse at the time of the observation revealed the resident had contractures to both her hands and the area would appear, get better and reappear off and on. An interview was conducted on 3/12/19 at 9:35 AM with the Infection Control Nurse. She stated she was responsible for receiving and reporting lab results Monday through Friday and she did receive the results of the wound culture on 1/13/20 and handed them to the nurse practitioner. She stated on the weekends, the laboratory drops the results into PCC (the electronic health record) and the floor nurse responsible for the resident was responsible for receiving and reporting abnormal results. She stated the nurse wouldn ' t have to call the on-call nurse practitioner on the weekend if the resident wasn ' t running a fever.	F 580	Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Jacob's Creek Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 1/14/2020 the nurse practitioner visited Resident #111 and documented on her Right 3rd finger, thumb/hand. On 1/16/2020 the nurse practitioner visited Resident #111 and documented on her Right 3rd finger, thumb/hand and initiated prophylactic antibiotic treatment and wound consult. On 3/31/2020 the director of nursing reviewed all residents with labs ordered from 1/6/2020 through 3/31/2020 to ensure that provider had notification and provider prescribed orders, if any, were being carried out as ordered. On 3/30/2020 the director of nursing initiated and completed re-education to all unit managers on notification of changes to physician/nurse practitioner/resident representative, to include abnormal lab results. This education will be part of the orientation process for all newly hired unit managers. The facility interdisciplinary team members will review in clinical meeting	

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F 580	Continued From page 3 An interview was conducted on 3/12/19 at 10:52 AM with Nurse #3 who revealed she was working the day shift on 1/11/20 but was not aware there was a wound culture report pending for Resident #111. She stated the laboratory dropped the results into PCC but the system didn ' t alert her to it. She stated she would have had to know there were results pending and she wasn ' t notified. She stated if she had gotten the results, she would have called the nurse practitioner or physician on call and placed the resident on contact precautions. Nurse #3 stated Resident #111 wasn ' t febrile and showed no signs of infection. A follow up interview was conducted with the treatment nurse on 3/12/20 at 11:07 AM. She stated while she was completing the treatment for Resident #111 on 1/6/20, she observed increased redness and drainage to her left hand at her thumb and obtained a wound culture. She stated she put a note in the nurse practitioner ' s book to let her know what she did. She stated she wouldn ' t have told the nurse on the floor providing care to Resident #111 that a wound culture was pending, just the physician or nurse practitioner. An interview was conducted on 3/12/20 at 12:22 PM with the nurse practitioner. She revealed she did see the culture result on 1/13/20 and assessed Resident #111 ' s wound on 1/14/20. She stated at that time, she saw nothing unremarkable and decided to obtain a CBC to further assess for infection. She stated she saw the wound again on 1/16/20 and the appearance was a little different, so she went ahead and ordered the antibiotic therapy. She stated the results of the wound culture should have been	F 580	the physician orders dated from previous to current meeting 5 days per week for 90 days, to determine potential changes of conditions in resident conditions, to include timely notification of provider of any abnormal lab results. The Compliance Monitoring Tool will be utilized. Immediate action and/or re-education will be completed if any areas are identified. To maintain, the results of the follow up items and compliance will be submitted to the facility's Quality Assurance meeting monthly for 3 months and as needed.	

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F 580	Continued From page 4 called to the on call nurse practitioner on 1/11/20 when they were received by the facility.	F 580		
F 584 SS=C	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. (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	F 584		4/9/20

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F 584	Continued From page 5 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 and staff interviews, the facility failed to maintain clean floors in 1 of 6 hallways (100 hall) and failed to maintain clean exterior exit doorways for 3 of 6 halls (100, 400 and 600 hallways). The findings included: An observation on 3/9/20 at 12:09 PM revealed multiple areas of what appeared to be dried spills or other substances on the 100-hall floor. Dark build-up was observed in most of the resident room door thresholds, especially heavy and noticeable in rooms 117, 123 and 125. Dark build up was also heavy on the floor from the 100 hall toward the 200 hall. An observation on 3/10/20 at 9:19 AM revealed multiple areas of what appeared to be dried spills or other substances on the 100-hall floor. Dark build-up was observed in most of the resident room door thresholds, especially heavy and noticeable in rooms 117, 123 and 125. Dark build up was also heavy on the floor from the 100 hall toward the 200 hall. An observation on 3/11/20 at 10:05 AM revealed Housekeeper #1 mopping the floor of the 100 hall from the end of the nurses station to room 120. After mopping, the floor remained with the same areas of what appeared to be dried spills or other	F 584	Jacob's Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob's Creek Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Jacob's Creek Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 3/12/2020 the housekeeping assistant supervisor cleaned the 100 hall floor and the 100 hall exterior exit doorway. On 3/12/2020 a plan to clean all floors was initiated and to continue on a routine	

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F 584	Continued From page 6 substances. Dark build up remained in the resident room thresholds. On 3/11/20 at 10:09 AM, an interview was conducted with the Housekeeping Director Assistant. She stated each housekeeper was responsible for the floors in the hallways of their room assignment. She stated there were many areas that could not be removed with mopping and the floor will need a "top scrub" which would remove the areas or a full stripping and waxing. She stated she did not have a schedule of when the floors were to be scrubbed or stripped and waxed but it was done every 6-7 months. She stated the facility just started stripping and waxing the facility hallways on 3/9/20. She stated they had a floor technician that buffed the floors every day. An observation on 3/11/20 at 11:00 AM revealed the floor technician buffing the hallway outside rooms 105-120. After the buffing was completed, the floors appeared shinier, but areas of dried spills and substances remained as well as darkened areas of resident room thresholds. On 3/11/20 at 11:15 AM, an interview was conducted with the floor technician. He stated he had only been working at the facility for about a month and half and that he didn ' t buff all the floors every day. He stated when he began working, there wasn ' t a schedule for cleaning and buffing the floors, so he made his own. He consulted the schedule and stated he hadn ' t buffed the floors on the 100 hall since 2/25/20. He stated there was a crew that started stripping and waxing the floors at night that began on 3/9/20. An observation on 3/12/20 at 2:00 PM of the	F 584	schedule. On 3/30/2020 the housekeeping assistant supervisor cleaned all exterior exit doorways. On 3/31/2020 the administrator initiated and completed re-education to the housekeeping supervisor and the housekeeping assistant supervisor on a safe/clean/comfortable/homelike environment, to include floors and exterior exit doorways. This education will be part of the orientation process for all newly hired housekeeping supervisors and/or housekeeping assistant supervisors. The facility interdisciplinary team members will review facility environment in administrative rounds, to include floors and the exterior exit doorways. The Compliance Monitoring Tool will be utilized. Immediate action and/or re-education will be completed if any areas are identified. To maintain, the results of the follow up items and compliance will be submitted to the facility's Quality Assurance meeting monthly for 3 months and as needed.	

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F 584	Continued From page 7 exterior exit door on the 600 hall revealed the door was covered with cobwebs and debris. At 2:08 PM, the exterior door of the 400 hall was observed revealing it also was covered with multiple cobwebs. On 2:13 PM, the exterior door of the 100 hall was observed revealing it was also covered with cobwebs and debris. A follow up interview with the Housekeeping Director Assistant on 3/12/20 at 2:30 PM revealed each housekeeper was responsible for cleaning the exterior exit doors in their assigned areas. She stated they should be getting cleaned when they are dirty. She stated she or the Housekeeping Director train new housekeepers on what they are responsible for cleaning. An interview on 3/12/20 at 2:35 PM with Housekeeper #1 revealed she was new to the facility and wanted to clean the exterior exit doors but had not been told she was responsible for doing so. An interview was conducted on 3/12/20 at 3:02 PM with the Administrator. She stated they have a different company that took over providing the chemicals for floor stripping and waxing and the staff was just inserviced and they began stripping and waxing the floors this week.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and nurse practitioner interviews, the facility failed to	F 641	Jacob's Creek Nursing and Rehabilitation Center acknowledges receipt of the	4/9/20

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F 641	Continued From page 8 accurately code the Minimum Data Set (MDS) assessment in the areas of 1. Active Diagnoses for 1 of 2 residents (Resident #111) reviewed for pressure ulcers and, 2. Falls for 1 of 2 residents (Resident #6) reviewed for falls. The findings included: 1. Resident #111 was admitted to the facility on 7/26/12 with diagnoses of contracture to left hand. A review of the quarterly MDS assessment dated 1/24/20 indicated Resident #111 had an active diagnosis of Methicillin resistant Staphylococcus aureus (MRSA) infection. Wound infection was not coded on the assessment. An observation on 3/11/20 at 9:02 AM revealed an open, reddened are to Resident #111 ' s inner left hand lateral palm at the thumb. Appeared excoriated. An interview with the Treatment Nurse at the time of the observation revealed the resident had contractures to both her hands and the area would appear, get better and reappear off and on. She stated in January it showed signs of infection and she obtained a wound culture and it did show methicillin resistant Staphylococcus aureus. She stated the Nurse Practitioner assessed the area and decided it should be treated and Resident #111 was placed on antibiotic therapy. A record review revealed a lab report dated 1/11/20 of a wound culture obtained on 1/7/20 from Resident #111 ' s left inner hand at thumb was positive for Methicillin resistant Staphylococcus aureus. A record review of a progress note by the Nurse	F 641	Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob’s Creek Nursing and Rehabilitation Center’s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Jacob’s Creek Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 3/10/2020 the minimum data set (MDS) coordinator reviewed the MDS assessment dated 1/24/2020 and submitted a corrected MDS assessment to the national repository on 3/31/2020 for Resident #111. On 3/31/2020 the MDS coordinator reviewed the MDS assessment dated 12/2/2019 and submitted a corrected MDS assessment to the national repository on 3/11/2020 for Resident #6. On 3/31/2020 the MDS Nurses reviewed a 100% of residents with wound cultures for the past 3 months to ensure that all MDS assessments were accurately coded and	

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F 641	Continued From page 9 Practitioner dated 1/16/20 revealed Resident #111 ' s wound to her left hand at the thumb was exhibiting purulent drainage and antibiotic therapy was initiated. A physician ' s order was reviewed dated 1/16/20 for Clindamycin 600 milligrams every 8 hours for finger infection for 10 days. A review of the January Medication Administration Record revealed Resident #111 received Clindamycin 600 milligrams every 8 hours beginning on 1/16/20 and 2:00 PM and ending on 1/26/20 at 6:00 AM. An interview was conducted on 3/12/20 at 2:34 PM with the MDS coordinator. She revealed she saw where Resident #111 was coded for MRSA but the wound infection did not get coded. 2. Resident #6 was admitted to the facility on 5/24/16 with diagnoses of osteoporosis and osteoarthritis. A review of a significant change in assessment Minimum Data Set assessment (MDS) dated 12/2/19 revealed Section J coded as yes for fall with major injury. A review of falls for Resident #6 did not indicate she sustained a fall with major injury during the assessments look back period. An interview was conducted on 3/12/20 at 2:34 PM with the MDS coordinator. She stated Resident #6 had a fall with major injury in November of 2018 and the MDS dated 12/2/19 was coded in error.	F 641	revised immediately as necessary. On 3/31/2020 the MDS nurses reviewed 100% residents that sustained falls in the past 6 months to ensure that all MDS assessments were accurately coded and revised immediately as necessary. On 3/30/2020 the administrator initiated and completed re-education to all MDS nurses on accuracy of assessments, to include wound infections and falls. This education will be part of the orientation process for all newly hired MDS nurses. The director of nursing will review all residents quarterly to ensure that all residents quarterly assessments to ensure that all MDS assessments accurately reflect each resident, to include wound infections and falls every 3 months. Immediate action and/or education will be completed if any areas are identified. To maintain, the results of the follow up items and compliance will be submitted to the facility's Quality Assurance meeting monthly for 3 months and as needed.	

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F 644	Continued From page 10	F 644		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a resident assessment for a Level II PASRR (Preadmission Screening and Resident Review) was completed for 1 of 1 sampled resident (Resident #9) reviewed for Level II PASRR. Findings included: Review of Resident #9 ' s Annual Minimum Data Set (MDS) dated 5/17/19 revealed that Resident #9 had been admitted to the facility on 7/03/2018 and presently had diagnoses of psychosis, anxiety disorder and psychotic disorder with delusions.	F 644	Jacob's Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob's Creek Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor	4/9/20

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	345050	A. BUILDING _____ B. WING _____	C 03/12/2020

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 644	Continued From page 11 Review of the PASRR Level I Determination Notification letter dated 7/03/18 revealed that "No further PASRR screening is required unless a significant occurs with the individual ' s status which suggests a diagnosis of mental illness or mental retardation, or if present, suggests a change in treatment needs for those conditions." Review of Resident #9 ' s medical record revealed a new diagnosis of psychotic disorder with delusions dated 12/02/19. In an interview on 3/11/20 at 11:23 AM Social Worker #1 stated usually the Admission Coordinator records the data in the system and she had been out on leave. Social Worker #1 expressed having no knowledge of Resident #9 ' s evaluation for a Level II PASRR. In an interview on 3/11/20 at 11:30 AM Social Worker #2 explained there was coordination between Admission Coordinator, MDS Nurse, and Social Work for PASRR processing. She stated Resident #9 may have been missed during the process since the Admission Coordinator had been absence. Social Worker #2 explained there was no record of a Level II PASRR filed for Resident #9 with his added diagnosis of psychotic disorder with delusions. In an interview on 3/11/20 at 11:40 AM MDS Nurse #1 expressed she entered data on the annual MDS assessment and the diagnoses were added, but she had no knowledge of a Level II PASRR for Resident #9. In an interview on 3/11/20 at 12:30 PM the Administrator stated the staff missed the	F 644	does it constitute an admission that any deficiency is accurate. Further, Jacob's Creek Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 3/13/2020 the social worker submitted Resident #9 for an assessment to determine PASARR level. On 3/25/2020 the minimum data set (MDS) nurses reviewed 100% residents to ensure that PASARR assessments and level determinations were completed as necessary. The MDS nurses and social services revised assessments and determinations immediately. On 3/12/2020 the administrator initiated and completed re-education to all MDS nurses and social services on coordination of PASARR and assessments to include those upon admission from the hospital. This education will be part of the orientation process for all newly hired MDS nurses and/or social services. The admission coordinator and/or designee will review all new admissions and re-admission PASARR levels to ensure that they are coordinated and assessed as necessary. The MDS nurse and/or designee will review 10% of all PASARR's to ensure	

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F 644	Continued From page 12 submission for the Level II PASRR and the facility would be addressing the missed evaluation immediately.	F 644	that they are coordinated and assessed as necessary for 3 months. Immediate action and/or education will be completed if any areas are identified. To maintain, the results of the follow up items and compliance will be submitted to the facility's Quality Assurance meeting monthly for 3 months and as needed.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff and nurse practitioner interviews, the facility failed to 1. obtain a physician ordered lab test for 1 of 2 residents (Resident #111) reviewed for pressure ulcers and, 2. Failed to correctly transcribe a prn (as needed) psychotropic medication order from a written telephone order to the electronic health record (EHR) for 1 of 5 residents (Resident #26) reviewed for unnecessary medications. The findings included: 1. Resident #111 was admitted to the facility on 7/26/12 with diagnosis of contracture to left hand. A record review revealed a laboratory culture report dated 1/11/20 from a wound culture of Resident #111 ' s left hand at the thumb that was collected on 1/7/20. The wound culture showed Methicillin resistant Staphylococcus aureus (MRSA).	F 658	Jacob's Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob's Creek Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Jacob's Creek Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of	4/9/20

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F 658	Continued From page 13 A record review revealed a physician ' s order dated 1/14/20 to obtain a CBC (complete blood count) on the next lab day for Resident #111. There was no evidence in the chart that a CBC was collected until 2/5/20. The nurse practitioner ' s progress note dated 1/16/20 revealed Resident #111 was seen for acute on chronic wound on thumb/hand. An aerobic bacterial culture showed heavy growth of Staphylococcus aureus methicillin resistant. The note further indicated the nurse practitioner saw the resident on 1/14/20 and the wound looked unremarkable and the wound nurse affirmed wound was no longer draining and as red as before, even the swelling had gone down. CBC (complete blood count) ordered for 1/15/20. Today, purulent drainage noted in the wound. Clindamycin, antibiotic, with probiotic and wound consult initiated. An interview was conducted on 3/12/19 at 9:35 AM with the Infection Control Nurse. She stated she was responsible for receiving and reporting lab results Monday through Friday and on the weekends, the laboratory drops the results into PCC (the electronic health record) and the floor nurse responsible for the resident was responsible for receiving and reporting abnormal results. She stated she received results of the wound culture that was obtained on 1/7/20 and gave them to the nurse practitioner on Monday, 1/13/20 who wanted to obtain a CBC to see if Resident #111 ' s white blood count was elevated before deciding to place the resident on an antibiotic. The Infection Control Nurse reported back to the surveyor at 9:45 AM that the CBC would have been collected on Resident #111 ' s	F 658	Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 2/5/2020 the unit manager obtained the lab ordered by physician on 1/14/2020 for next lab day for Resident #111. On 3/12/2020 the unit manager correctly transcribed the prn psychotropic medication in the electronic health record (EHR) for Resident #26. On 3/31/2020 the director of nursing reviewed all residents with labs ordered from 1/6/2020 through 3/31/2020 to ensure that labs were obtained as prescribed and ordered by provider. On 3/12/2020 the director of nursing reviewed all residents with prn psychotropic medications ordered to ensure they were correctly transcribed in the EHR and revised immediately as necessary. Any negative findings were addressed. On 3/30/2020 the director of nursing initiated and completed re-education to all unit mangers on obtaining labs as ordered by physician. This education will be part of the orientation process for all newly hired unit managers. On 3/12/2020 the staff facilitator initiated re-education to all licensed nurses on correctly transcribing orders into the EHR, to include prn psychotropic medications. No licensed nurse will be allowed to work after date until re-education is complete. This education is part of the orientation for	

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F 658	Continued From page 14 next lab day. An interview was conducted on 3/12/20 at 9:53 AM with the Restorative Nurse who revealed the lab technician comes to the facility every day to draw and collect labs. An interview was conducted on 3/12/20 at 12:22 PM with the nurse practitioner. She revealed she received results of a wound culture obtained from Resident #111 ' s left hand on Monday, 1/13/20 and assessed Resident #111 ' s wound on 1/14/20. She stated at that time, she saw nothing unremarkable and decided to obtain a CBC to further assess for infection. The order was written on 1/14/20 to obtain the CBC on the next lab day and she expected the CBC to be collected the next day and didn ' t know why it wasn ' t collected. 2. Resident #26 was admitted to the facility on 5/22/19 with diagnoses that included anxiety disorder and depression. The quarterly Minimum Data Set assessment dated 12/30/19 revealed Resident #26 was cognitively intact. He received anti-anxiety medication for seven of seven days of the look back period. A care plan problem updated 1/10/20 included anxiety. A care plan intervention stated, "give medication as prescribed by physician." A telephone physician order dated 2/17/20 in Resident #26's hard chart stated, "Klonopin (an anti-anxiety medication), 0.5 milligrams (mg) every evening prn anxiety times 14 days-no	F 658	newly hired nurses. By 4/9/2020 all licensed nursing staff, newly hired licensed nursing staff and agency staff will be re-educated by the staff facilitator on correctly transcribing orders into the EHR, to include prn psychotropic medications. This education will be part of the orientation process for all newly hired licensed nursing staff, including agency staff. The facility interdisciplinary team members will review in daily clinical meeting the physician orders dated from previous to current meeting, to review 5 days per week for 90 days, to determine any new orders, to include labs and prn psychotropic medications. The Compliance Monitoring Tool will be utilized. Immediate action and/or re-education will be completed if any areas are identified. To maintain, the results of the follow up items and compliance will be submitted to the facility's Quality Assurance meeting monthly for 3 months and as needed.	

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F 658	Continued From page 15	F 658		

refills."

An order in the EHR dated 2/17/20 revealed, "Klonopin, 0.5mg, give by mouth every 24 hours as needed for anxiety at bedtime only." There was no end date or duration listed on the order in the EHR.

The February medication administration record (MAR) indicated Resident #26 received prn Klonopin on 2/17, 2/18, 2/21, 2/22, 2/25, 2/27, 2/28 and 2/29.

The March MAR demonstrated Resident #26 received prn Klonopin on 3/1, 3/2, 3/3, 3/4, 3/5, 3/6, 3/7, 3/8, 3/9 and 3/10.

On 3/12/20 at 9:50 AM an interview was completed with Resident #26. He said he took Klonopin twice a day routinely and also had an order for the Klonopin to be given prn in the evening. He expressed that he took the Klonopin for his anxiety, typically requested the prn dose at night and that it helped him.

During an interview with Nurse #1 on 3/11/20 at 2:28 PM, she explained that Resident #26 requested Klonopin daily and told staff if he felt nervous or anxious.

An interview was completed with Nurse #2 on 3/12/20 at 8:58 AM. She stated nurses entered the handwritten telephone orders into the EHR. She recalled she was in orientation with Nurse #1 when the telephone order was written for prn Klonopin and she entered it into the EHR as "routine" and the nurse who she was orienting with had corrected the order so that it reflected prn.

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F 658	Continued From page 16 On 3/12/20 at 9:06 AM a follow up interview was completed with Nurse #1 during which she said nurses entered the handwritten telephone orders into the EHR. She explained the prn Klonopin order was not correctly entered into the EHR. Nurse #1 added she had not overseen Nurse #2 and had not made any corrections to the order and stated, "She (Nurse #2) must have taken it upon herself to enter it in. She must have forgot to put the duration in." An interview with the Administrator on 3/12/20 at 9:26 AM revealed when a telephone order was received the nurse entered it into the EHR. She explained the nurse who entered the order in the EHR was new and listed the end date as indefinite. The Administrator added that typically the nurse who received the order for a prn psychotropic entered it into the computer with a 14 day stop date. She confirmed that the 14 day stop date should have been 3/1/20.	F 658		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced	F 687		4/9/20

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F 687	Continued From page 17 by: Based on observations, resident and staff interviews and medical record review, the facility failed to obtain podiatry services for 1 of 1 resident (Resident #130) reviewed for foot care. Findings included: Resident #130 was admitted to the facility on 7/23/19 with diagnoses that included, in part, heart failure, hypertension and chronic obstructive pulmonary disease. The quarterly Minimum Data Set assessment dated 2/13/20 revealed Resident #130 had moderately impaired cognition. She required extensive assistance with her personal hygiene. A care plan updated 2/26/20 included a problem related to activities of daily living/personal care. An intervention included, "provide extensive physical assistance" with personal hygiene/grooming. On 3/9/20 at 12:51 PM an observation of Resident #130's feet revealed long and thick toenails on both feet. Resident #130's medical record was reviewed and revealed the resident representative signed consent on 7/23/19 for the resident to be seen by the podiatrist. Further review indicated Resident #130 had not been seen by a podiatrist since her admission. An interview was completed with Social Worker (SW) #1 on 3/11/20 at 8:53 AM. She stated a podiatry service came to the facility approximately every 2-3 months and saw about 40 residents at	F 687	Jacob's Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob's Creek Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Jacob's Creek Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 3/31/2020 the social worker confirmed that Resident #130 is on the list to receive podiatry services on their next visit on 4/9/2020. On 3/31/2020 social services reviewed 100% of residents that have consented to podiatry services to ensure that they had received them as consented and placed them on the next podiatry visit list as necessary. Any negative findings were addressed.	

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F 687	Continued From page 18 each visit. She explained when a resident was admitted to the facility the resident representative signed a waiver that gave permission for the resident to be seen by the podiatrist. The facility sent the signed waiver to the podiatry service and then the podiatrist sent a consent form to the resident's primary care physician for authorization. SW #1 added that all residents were on the list for podiatry services. She said the podiatrist was scheduled again at the facility on 4/9/20 and provided a list of residents who were scheduled to be seen at that time. Resident #130 was not on the list. SW#1 reviewed the podiatry list from 7/23/19 to 3/11/20 and reported, "I don't see that she's been on the list to be seen." During an interview with Nurse #4 on 3/11/20 at 9:08 AM she explained that if a resident or family member told her they needed to see the podiatrist then she told the SW. Nursing also notified the SW of podiatry needs if the nurse or aide noticed a resident's toe nails were too long when they provided care. An observation of Resident #130's toenails was completed with Nurse #4 after the interview and the nurse described the resident's toenails as "long and thick" and stated, "she would be someone who would need to be seen by the podiatrist." An interview was completed with Resident #130 during the observation and she said her toenails did not hurt and were not uncomfortable. The Director of Nursing (DON) was interviewed on 3/11/20 at 9:20 AM. During the interview, an observation was made with the DON of Resident #130's feet. The DON expressed that the resident's toenails were long and thick and said Resident #130 was "probably on the list to be seen by podiatry." She explained that both nurse	F 687	On 3/30/2020 the administrator initiated and completed re-education to social services on resident foot care, to include podiatry services as necessary. This education will be part of the orientation process for all newly hired social services. The administrator, director of nursing and/or unit manager will audit 10% of residents monthly for 3 months to ensure podiatry services were provided as ordered and consented in the past 60 days. The Compliance Monitoring Tool will be utilized. Immediate action and/or re-education will be completed if any areas are identified. To maintain, the results of the follow up items and compliance will be submitted to the facility's Quality Assurance meeting monthly for 3 months and as needed.	

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F 687	Continued From page 19 aides and nurses were able to cut fingernails and toenails of residents. The DON said that based on her observation of Resident #130's feet, she needed to be seen by the podiatrist. On 3/12/20 at 9:36 AM an interview was completed with the Administrator. She stated the podiatrist had only been in the facility twice since July 2019 and was scheduled again for April 2020. She added the podiatrist only saw 40 residents at a time. A follow up interview was completed with SW #1 on 3/12/20 at 10:21 AM. She provided a list of dates that the podiatrist had been in the building since July 2019 which included 9/18/19, 11/1/19, 11/7/19, 1/5/20, and 2/10/20. SW#1 said she had talked to the podiatry service provider and discovered that after the service received the signed consent form from the resident representative, they had not sent an order to the facility physician for signature.	F 687		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure Nursing Assistants (NA's) received annual Dementia and Abuse/Neglect training. This was for 1 of 5 NA's reviewed for	F 730	Jacob's Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that	4/9/20

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F 730	Continued From page 20 staffing. The findings included: Facility personnel file review was conducted on 3/12/2020 at 1:15 pm of five randomly picked clinical staff members. Investigation revealed that NA #1 was due for annual Dementia and Abuse/Neglect training on 10/23/2019 and received no in-service training for the 2019 calendar year. An interview was conducted with the Staff Development Coordinator (SDC) on 3/12/2020 at 1:15 pm who advised that she had hired into that role in November 2019 and, as far as she knew, there had not been anyone in the SDC role for almost a year prior. She stated that she was currently working on making sure all employees received the required training for their individual jobs. During an interview on 3/12/2020 at 1:30 pm, the Director of Nursing (DON) stated that there was someone in the SDC role last year but that she was terminated about three months prior to the current SDC being hired. The DON revealed that she was terminated near the end of September because the facility felt like she wasn't doing her job properly. Therefore, the facility had gone a few months without an SDC. During an interview on 3/12/2020 at 3:10 pm, the Administrator was advised of the lack of annual training and she stated when the previous SDC left last fall, the task of ensuring staff training did not get completed as expected. She felt confident that the situation would resolve with the current SDC in place.	F 730	the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob's Creek Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Jacob's Creek Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 3/30/2020 the staff facilitator initiated and completed Dementia and Abuse/Neglect training to nursing assistant #1. On 3/12/2020 the staff facilitator reviewed 100% of nursing assistants to ensure each had annual training, to include Dementia and Abuse/Neglect and corrected immediately as necessary. On 3/31/2020 the administrator initiated and completed re-education to the director of nursing and the staff facilitator on Nurse Aide Performance Review – 12hr/yr In-services, to include Dementia and Abuse/Neglect training. This education will be part of the orientation	

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	345050	A. BUILDING _____ B. WING _____	C 03/12/2020

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 730	Continued From page 21	F 730	process for any newly hired director of nursing and or staff facilitator. The director of nursing and/or administrator will review 10 nurse aide education files monthly for 3 months to ensure the mandatory education has been completed in the last 12 months. The Compliance Monitoring Tool will be utilized. Immediate action and/or re-education will be completed if any areas are identified. To maintain, the results of the follow up items and compliance will be submitted to the facility's Quality Assurance meeting monthly for 3 months and as needed.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		4/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 22 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, record review and staff interview, the facility failed to safely and securely store medications observed to be left at the bedside for 1 of 32 sampled residents (Resident # 138) reviewed. The findings included: Resident was admitted to the facility on 4/10/12 with diagnoses of osteoporosis, vitamin d deficiency and osteoarthritis. On 3/9/20 at 10:55 AM an observation was made of Resident #138 lying in her bed. On the nightstand beside Resident #138 ' s bed was a 1-ounce plastic medicine cup with a dime sized pink tablet inside it. A record review revealed an order for Calcium Carbonate chewable 500 milligrams daily ordered on 8/8/18. A record review revealed Resident #138 did not have an order to self-administer medications. The record review further revealed no assessment for self-administering medications. An interview was conducted on 3/9/20 at 11:00 with Nurse #3. She stated she was assigned to Resident #138 and administered her medications that morning. She stated the pink tablet was a	F 761	Jacob's Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Jacob's Creek Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Jacob's Creek Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 4/1/2020 the director of nursing observed licensed nurse administer Resident #138 her medications. On 4/1/2020 the administrative nurses observed all licensed nurses administer	

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	345050	A. BUILDING _____ B. WING _____	C 03/12/2020

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JACOB'S CREEK NURSING AND REHABILITATION CENTER	1721 BALD HILL LOOP MADISON, NC 27025

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F 761	Continued From page 23 tums and should not be at the bedside. She stated "she should have already taken that".	F 761	medications to residents. No negative findings noted. On 4/1/2020 the staff facilitator initiated re-education on all licensed nurses and medication aides, including agency staff, on labeling/storage of drugs and biologicals, to include medications not being left at bedside. This education was completed on 4/9/2020 or no licensed nurse or medication aide will be allowed to work after date until education is completed. This education is part of the orientation foe newly hired licensed nurses and medications aides. By 4/9/2020 all licensed nurses and medication aides, including agency staff, will be re-educated by the staff facilitator on proper labeling/storage of drugs and biologicals, to include medications not being left at bedside. This education will be part of the orientation process for all newly hired licensed nursing staff, including agency staff. Facility pharmacist and/or the director of nursing will perform random medication pass audits 3 times a week for 4 weeks, then weekly for 8 weeks and as needed. The Compliance Monitoring Tool will be utilized. Immediate action and/or re-education will be completed if any areas are identified. To maintain, the results of the follow up items and compliance will be submitted to the facility's Quality Assurance meeting monthly for 3 months and as needed.	