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 01/11/2022

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 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain	E 036		2/11/22

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

Electronically Signed | 02/09/2022

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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E 036	Continued From page 1 an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain an annual emergency preparedness training for facility staff. Findings included: A review of the facility's emergency preparedness training manual was conducted on 1/6/22 and did not include any information on training or testing of the emergency preparedness plan for the facility staff. During an interview with the director of nursing on	E 036	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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E 036	Continued From page 2 1/6/22, she stated that they did not currently have a staff development coordinator and that the facility was behind on the required yearly training for the staff. She stated that they had done several fire and/or tornado drills but that was all. She stated that the recently signed up with an online computer program that will allow them to track and complete the necessary training for all staff. On 1/11/22, the facility administrator indicated that she felt sure they had completed training on the emergency preparedness manual but was unable to locate the required documentation within the previous staff development coordinator's office.	E 036	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. How correction action will be accomplished for those residents found to have been affected by the deficient practice On 1/20/2022 the administrator reviewed the facility Emergency Preparedness Plan Manual for the Training. On 1/20/2022 the administrator ensured the facility plan included the requirements for facility training. How the facility will identify other residents having the potential to be affected by the same deficient practice On 1/20/2022 the administrator reviewed the facility Emergency Preparedness Plan Manual for the Training. On 1/20/2022 the administrator ensured the facility plan included the requirements for facility training. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur	

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E 036	Continued From page 3	E 036	On 1/20/2022 the administrator, director of nursing and/or staff development coordinator initiated mandatory re-education for all nursing, dietary, administrative, housekeeping, therapy and activities staff. All new hires during their orientation and during orientation for all agency staff will be educated on the Emergency Management Plan. The administrator, beginning January 2022 and annually thereafter, will review the Emergency Preparedness Manual with the facility Department Heads, they will approve the manual, make recommendations for additional training and/or testing. How the facility plans to monitor its performance to make sure solutions are sustained The staff development coordinator will provide the administrator with the education sign in sheet for all the new hires and agency staff monthly. The administrator will review and place them in the Emergency Preparedness Manual. Concerns or trends will be reviewed and discussed at the Cardinal Interdisciplinary Team Meeting as needed. The findings will be given to the Quality Assurance Performance Improvement meeting monthly for two months to determine trends and/or issues that may need further interventions put in place and to determine the need for further and/or frequency of monitoring.	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 4 A recertification and complaint investigation was conducted from 1/02/2022 through 1/11/2022.Event ID# TZ2F11 Immediate Jeopardy was identified at: CFR 483.90 at tag F919 and F835 at a scope and severity K. Immediate Jeopardy began on 1/02/2022 and was removed on 1/06/2022. 9 of the 30 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		2/11/22

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F 550	Continued From page 5 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident representative interview, staff interviews and record review, the facility failed to provide a dignified dining experience by standing while providing assistance with feeding for 1 of 8 residents (Resident #83) reviewed for assistance with dining. Findings included: Resident #83 was admitted to the facility on 1/21/19 with diagnoses that included, in part, dementia, gastro-esophageal reflux disease, and contracture of right and left hand. The quarterly Minimum Data Set assessment dated 12/13/21 revealed Resident #83 had severely impaired cognition. She required extensive assistance with eating.	F 550	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	

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F 550	Continued From page 6 An activities of daily living care plan updated 12/27/21 revealed, "Provide extensive to total feeding assistance, remaining with patient throughout meal..." On 1/2/22 at 12:35 PM Resident #83 was observed in her bed in an upright seated position. She was being fed by Nurse Aide (NA) #3. NA #3 stood next to the resident's bed as she provided the resident with feeding assistance. NA #3 stood above eye level of the resident for the duration of the meal while she fed Resident #3. At 12:38 PM NA #3 removed the lunch tray from Resident #83's overbed table and exited the room. An interview was completed with NA #3 on 1/2/22 at 12:39 PM, during which she stated Resident #83 had to be fed her meal. She said she typically stood up when she fed residents, including Resident #83. NA #3 shared the facility hadn't specifically educated staff whether they should be seated or stand when they fed a resident. Resident #83's representative was interviewed by phone on 1/3/22 at 1:45 PM. He thought Resident #83 would want staff to be seated when they fed her to promote a more dignified dining experience. He added when he visited the resident and fed her, he always sat in a chair next to her bed. During an interview with the Director of Nursing (DON) on 1/6/22 at 3:34 PM, she explained staff should be seated at eye level when they fed a resident. She explained NAs learned this process when they went through NA training and it was also reviewed during the new orientation	F 550	deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. How correction action will be accomplished for those residents found to have been affected by the deficient practice On 1/12/2022 Resident #83 was observed by assistant director of nursing during mealtime and nurse aide was sitting at bedside while assisting Resident #83 with feeding. How the facility will identify other residents having the potential to be affected by the same deficient practice On 1/12/2022 the assistant director of nursing reviewed all residents that require feeding assistance to ensure that staff were providing a dignified dining experience, to include sitting while feeding assistance was being provided. There were no negative findings. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur 1/12/2022 the director of nursing and unit managers initiated re-education to all nurses, nurse aids and paid feeding assistants on providing a dignified dining experience, to include sitting while feeding assistance is being provided. All nurses,	

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F 550	Continued From page 7 process. The DON stated NA #3 should have been seated when she fed Resident #83.	F 550	nurse aids and paid feeding assistants will be re-educated by 2/11/2022. This education will be part of the orientation process for all newly hired nurses, nurse aids and paid feeding assistants, including agency staffing. How the facility plans to monitor its performance to make sure solutions are sustained The assistant director of nursing will review all residents that require feeding assistance weekly for four weeks and monthly for two months, utilizing the Resident Care Audit tool, to ensure a dignified dining experience is being provided, to include sitting while feeding assistance is being provided. Concerns or trends will be reviewed and discussed at the Cardinal Interdisciplinary Team Meeting 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 findings will be given to the Quality Assurance Performance Improvement meeting monthly for three months to determine trends and/or issues that may need further interventions put in place and to determine the need for further and/or frequency of monitoring.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that	F 554		2/11/22

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F 554	Continued From page 8 this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to assess the ability of a resident to self-administer medications that were left at bedside for 1 of 1 resident (Resident #62) reviewed for self-administration. The findings were: Resident #62 admitted to the facility on 05/03/2019 with diagnoses of, in part, vascular dementia and persistent mood disorder. A medication self-administration assessment dated 07/06/2020 revealed resident was deemed unable to safely administer medications due to memory problems. A quarterly Minimum Data Set assessment dated 11/04/2021 revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Record review revealed no order or care plan to indicate Resident #62 was able to self-administer medications. On 01/05/2022 at 09:00 AM, the surveyor entered Resident #62 ' s room and observed 14 pills of various colors, shapes and sizes on a paper towel on the counter next to the sink. Resident #62 was observed across the room at her nightstand and stated she didn ' t know what the blue capsule was and wasn ' t going to take her medications until she found out what it was. On 01/05/2022 at 9:05 AM, Nurse #1 was	F 554	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. How correction action will be accomplished for those residents found to have been affected by the deficient practice On 1/7/2022 Resident #62 was observed during medication pass taking her medications with nurse present at bedside. No medications were left at the bedside.	

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F 554	Continued From page 9 interviewed. She stated Resident #62 liked her medications spread out on a paper towel. She stated she knew she was supposed to watch residents take their medications but Resident #62 doesn ' t like her to stay in the room and watch her or she won ' t take the medications, so she just left them there. On 01/06/2022 at 3:15 PM, the Director of Nursing was interviewed. She stated Resident #62 was unable to safely self-administer her medications and they could not be left at the bedside.	F 554	How the facility will identify other residents having the potential to be affected by the same deficient practice On 1/7/2022 the unit managers searched all resident rooms to ensure that there were no additional medications at bedside unless the self-administer medications policy/procedure had been implemented. There were no negative findings. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur On 1/7/2022 the director of nursing and unit managers initiated re-education to all nurses and medication aides on self-administering medications if the interdisciplinary team had determined that it is clinically appropriate, to include not leaving medications at the bedside if it not clinically appropriate. All nurses and medication aides, including agency staffing, will be re-educated by 2/11/2022. This education will be part of the orientation process for all newly hired nurses and medication aides, including agency staffing. How the facility plans to monitor its performance to make sure solutions are sustained The director of nursing and/or unit managers will monitor all resident rooms for any medications that should be secured weekly for four weeks and monthly for two months, using the	

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F 554	Continued From page 10	F 554	Environment Rounding tool, to ensure that there are no medications at bedside unless the self-administer medications policy/procedure has been implemented. Concerns or trends will be reviewed and discussed at the Cardinal Interdisciplinary Team Meeting 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 findings will be given to the Quality Assurance Performance Improvement meeting monthly for three months to determine trends and/or issues that may need further interventions put in place and to determine the need for further and/or frequency of monitoring.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		2/11/22

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F 561	Continued From page 11 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to honor a resident's choice and get her out of bed as scheduled for 1 of 1 resident (Resident #72) reviewed for choices. Findings included: Resident #72 was admitted to the facility on 1/31/19. The quarterly Minimum Data Set assessment dated 11/12/21 revealed Resident #72 was cognitively intact. She required extensive assistance and the help of two staff members with transfers. Resident #72's care plan updated 11/23/21 included a focused area of daily and activity preferences. An intervention included the resident was an early riser and preferred to get up "around 5:00 AM." The daily staffing assignment sheet for the 100 hall (where Resident #72 resided) was reviewed. Instructions listed at the bottom of the assignment sheet read, "Get Up List: These residents must	F 561	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. How correction action will be accomplished for those residents found to	

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F 561	Continued From page 12	F 561		

be up. Third shift is responsible for all residents needed up by 5:00 AM." Resident #72 was included on the list of residents scheduled to get up by 5:00 AM.

An observation of and interview with Resident #72 was completed on 1/2/22 at 11:40 AM. The resident was seated up in her bed. Resident #72 said she wanted to get up every day at 5:00 AM but was not gotten up by staff on 1/2/22. She added no one came in her room in the morning and offered to get her out of bed. She explained she didn't need to get dressed in street clothes, only that she wanted to be transferred out of bed to her wheelchair.

During a phone interview with Nurse Aide (NA) #4 on 1/6/22 at 8:43 AM, she shared she worked with Resident #72 on third shift 1/1/22 from 11:00 PM-1/2/22 to 7:00 AM. She recalled she provided incontinence care to the resident during the shift. NA #4 said she had not gotten Resident #72 up on 1/2/22 since there were only two NAs who worked the hall and they focused on providing incontinence care to the residents on that hall. NA #4 added they normally had 3-4 aides who worked Resident #72's hall on third shift and thought since it was a holiday they were short staffed that night and she was unable to assist Resident #72 out of bed at her requested time of 5:00 AM.

On 1/4/22 at 9:34 AM Resident #72 was observed seated up in her bed. In an interview with the resident at 9:35 AM, she reported staff told her during the third shift they probably wouldn't be able to get her out of bed at 5:00 AM since there were only two staff members who worked the 100 hall. Resident #72 added staff

have been affected by the deficient practice

Resident #72 was got out of bed at requested time on 1/5/2022. Subsequently has got out of bed on 11pm-7am shift. No further concerns voiced by Resident #72.

How the facility will identify other residents having the potential to be affected by the same deficient practice

On 1/12/2022 the social worker interviewed all alert and oriented residents regarding resident's rights, to include self-determination and honoring their choices. There were no negative findings.

What measures will be put into place or systemic changes made to ensure the deficient practice will not recur

On 1/12/2022 the director of nursing and unit managers initiated re-education to all staff, including agency staff, on resident's rights, to include self-determination and honoring their choices. All staff, including agency staffing, will be re-educated by 2/11/2022. This education will be part of the orientation process for all newly hired staff, including agency staffing.

How the facility plans to monitor its performance to make sure solutions are sustained

The social workers will interview alert and oriented residents weekly for four weeks

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F 561	Continued From page 13 came into her room at 5:30 AM and provided incontinence care but did not get her out of bed. A phone interview was completed with NA #5 on 1/6/22 at 9:23 AM. She worked with Resident #72 on third shift 1/3/22 from 11:00 PM-1/4/22 to 7:00 AM. She explained the resident preferred that staff got her up at 5:00 AM. NA #5 said she left work early on 1/4/22, at 5:30 AM and there wasn't enough time to get the resident up at her requested time. An observation of Resident #72 on 1/6/22 at 9:20 AM revealed she was out of bed and seated in her wheelchair. During an interview with Resident #72 at 9:21 AM, she said staff had gotten her up at her preferred time 1/5/22 and 1/6/22. In an interview with the Director of Nursing (DON) on 1/6/22 at 3:30 PM, she stated there was a note on the NA assignment sheet that Resident #72 was to be gotten up at 5:00 AM daily. She added even if there were only two NAs who worked the hall they should have still gotten the resident out of bed. The DON added she sometimes called in during the night and reminded staff to get Resident #72 up at 5:00 AM per the resident's request.	F 561	and monthly for two months, using the Resident Choice Interview tool, to ensure that resident's rights are being honored, to include self-determination and honoring their choices. Concerns or trends will be reviewed and discussed at the Cardinal Interdisciplinary Team Meeting 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 findings will be given to the Quality Assurance Performance Improvement meeting monthly for three months to determine trends and/or issues that may need further interventions put in place and to determine the need for further and/or frequency of monitoring.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes	F 583		2/11/22

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F 583	Continued From page 14 accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to protect residents' private health information by leaving confidential medical information unattended and exposed on a medication cart and a medication cart computer in an area accessible to others for 1 of 5 medication carts observed. Findings included:	F 583	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.	

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F 583	Continued From page 15 On 1/4/22 at 9:43 AM an observation of the 400 hall revealed the medication cart was left unattended by staff. The medication cart computer was opened and exposed resident names and room numbers. A resident report sheet laid on top of the medication cart and exposed resident names, room numbers and medical information that included treatment information, vital signs and blood sugars. Medication Technician (Med Tech) #1 was observed down the hall where she stood outside a resident's room. In an interview with Med Tech #1 at 9:45 AM, she explained staff were supposed to lock the computer screen when they stepped away from the medication cart but that she had forgotten to lock the computer when she went down the hall to a resident's room. She added she typically left the resident report sheet face up on the medication cart and acknowledged the report sheet was visible to others when she walked away from the cart. During an observation of the unattended medication cart on the 400 hall on 1/5/22 at 8:30 AM, the computer was opened and resident names and room numbers were displayed on the screen. Nurse #2 was observed down the 400 hall and she walked towards the medication cart. An interview with Nurse #2 at 8:32 AM revealed she knew the residents' medical information was to be protected but had forgotten to lock the computer screen before she walked away from the medication cart. In an interview with the Director of Nursing (DON) on 1/6/22 at 3:37 PM, she shared when staff stepped away from a medication cart the computer screen should be locked and any paperwork with resident protected health	F 583	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. How correction action will be accomplished for those residents found to have been affected by the deficient practice On 1/4/2022 the director of nursing directed med tech #1 to put the 400-hall medication cart laptop screen in “hidden” mode and to cover up the 24-hour report. On 1/4/2022 this was confirmed to be done by the unit manager. How the facility will identify other residents having the potential to be affected by the same deficient practice On 1/4/2022 the unit managers audited all medication carts to ensure that all medication cart screens were in “hidden” mode and 24-hour reports were covered. There were no negative findings. What measures will be put into place or systemic changes made to ensure the	

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F 583	Continued From page 16 information turned over on the cart. She said Med Tech #1 and Nurse #2 should have turned over the resident report sheet and locked the computer screen before they left the medication cart unattended. The DON added staff had been educated in the past regarding the protection of residents' medical information.	F 583	deficient practice will not recur On 1/4/2022 the director of nursing and unit managers initiated re-education to all staff, including agency staff, on personal privacy/confidentiality of records, to include putting the medication cart laptop screen on “hidden” mode and covering the 24-hour report sheet. All staff, including agency staffing, will be re-educated by 2/11/2022. This education will be part of the orientation process for all newly hired staff, including agency staffing. How the facility plans to monitor its performance to make sure solutions are sustained The director of nursing and/or unit managers will monitor all medication carts for any unprotected resident personal/private information weekly for four weeks and monthly for two months, using the Environment Rounding tool, to ensure that medication cart laptop screens are in “hidden” mode and 24-hour report sheets are covered. Concerns or trends will be reviewed and discussed at the Cardinal Interdisciplinary Team Meeting 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 findings will be given to the Quality Assurance Performance Improvement meeting monthly for three months to determine trends and/or issues that may need further interventions put in	

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F 583	Continued From page 17	F 583	place and to determine the need for further and/or frequency of monitoring.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (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		2/11/22

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F 584	Continued From page 18 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 3 of 6 hallways (100, 200 and 500 halls). The findings included: 1. On 01/02/2022 at 10:00 AM, an initial tour was conducted of the 100 hallway. The floors in the hallway appeared to look dirty or stained from Room 111 to Room 137. Rooms 111, 113, 114, 117, 118, 119, 120, 121, 122, 124 125 127, 129, 131, 133, 135 and 137 had dark build up observed in the door thresholds. On 01/03/22 at 03:24 PM, an interview was conducted with a family member of a resident that resided on the 500-hall who stated the floors in the facility looked dull and scuffed up a lot and she didn ' t like her family member walking around barefoot on them. She stated she did see the staff mop the floors, but the floors need a good coat of old fashioned wax. On 01/04/2022 at 2:30 PM, an observation of the floors in the hallway on the 200 hall were observed to appear dirty and door thresholds were darkened, appearing dirty. An observation on 01/05/2022 at 11:15 AM revealed Housekeeper #1 mopping the floor of room 125. After mopping, there was no difference	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. How correction action will be accomplished for those residents found to have been affected by the deficient practice On 1/5/2022 the housekeepers on staff	

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F 584	Continued From page 19 in the appearance of the floor; the darkened area of the room ' s door threshold remained. Throughout the survey, there was no observation of a facility staff member cleaning the floors in the hallways. On 01/06/2022 at 11:16 AM, the Assistant Housekeeping Director was interviewed. She stated they have been trying to get the floors clean. She stated the new Housekeeping Director was new and he was out sick. She stated the 400 hall was stripped and waxed and they completed part of the 100 hall. She added the problem now is they don ' t have a floor technician; two were hired a couple of weeks ago and one of them just up and quit and another one was out sick and never returned. She stated the corporate office sent two floor technicians to help with cleaning the floors but they got sent to another facility. She stated it took a half of a day to strip and wax a room and there currently was no schedule for room cleaning. There was no on in the facility all week to clean the hallways of the facility. She added there was a lot of build up on the floors and it was going to be hard to remove and they may need new floors. On 01/07/2022 at 10:32, the Administrator was interviewed. She stated they have had a performance improvement plan in place since August of 2019. She stated the corporate office hired a contract company and they came in and got started on the floors and determined the tile was in need of repair because it was so old and worn. They did complete some corridors and rooms on the 400 hall and then they quit, and the company couldn ' t staff anymore for the facility. She stated she has started looking into replacing	F 584	swept and mopped all resident rooms and corridors, to include 100, 200 and 500 hall, with oversight from the administrator. How the facility will identify other residents having the potential to be affected by the same deficient practice On 1/7/2022 the administrator audited all floors, to include 100, 200 and 500 halls, to ensure all floors were clean. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur On 2/8/2022 the housekeeping supervisor initiated re-education on floor care cleanliness for all housekeeping staff. All housekeeping staff will be re-educated by 2/9/2022. This education will be part of the orientation process for all newly hired housekeeping staff. How the facility plans to monitor its performance to make sure solutions are sustained The Corporate Environmental Service Team stripped and waxed all facility floors from 1/12/22-1/18/22. However, despite all efforts, the stains remained on the floors. On 1/18/22, The Corporate Environmental Service Team reported to the Vice President of Construction and Design that the stains were not removable. It was determined by the Vice President of Construction and Design that	

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F 584	Continued From page 20 the floors and got measurements and is looking at prices of types of flooring to submit for approval. She stated she started this process about a week before the survey team entered the facility to conduct the recertification survey.	F 584	the stained floors would need to be replaced. On 1/18/22 The Vice President of Construction and Design devised a plan to initiate replacing the stained floors. The floor replacing project is projected to begin in April. Meanwhile, housekeeping will ensure floors remain free of removable dust and dirt with oversight by the Administrator. The housekeeping supervisor will monitor all floors, to include 100, 200 and 500 halls, weekly for four weeks and monthly for two months, utilizing the Environment Rounding Tool, to ensure floors of facility are clean. Concerns or trends will be reviewed and discussed at the Cardinal Interdisciplinary Team meeting 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 findings will be given to the Quality Assurance Performance Improvement meeting monthly for three months to determine trends and/or issues that may need further interventions put in place and to determine the need for further and/or frequency of monitoring.	
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	F 761		2/11/22

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F 761	Continued From page 21 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 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 observations and staff interviews the facility failed to remove expired medications from one of three medication carts (200 hall cart) and one of two medication rooms (500 hall medication storage room) reviewed for medication storage. The findings included: 1. Observations of the 200-hall cart was conducted on 1/6/2022 at 9:50 a.m. with Nurse #3. The observation revealed a locked drawer for narcotics that contained a medication card of Tramadol 50 mg with an expiration date of 11/1/2021. An interview was conducted with Nurse #3 on 1/6/2022 at 9:52 a.m. and she revealed she was	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	

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F 761	Continued From page 22 not aware the Tramadol had expired. She revealed the medication had not been administered since 11/2021 and she would immediately remove the medication to be returned to pharmacy for destruction. 2. Observations of the 500-hall medication storage room was conducted on 1/6/2022 at 10:14 a.m. with the Unit Supervisor present. The observation revealed a storage cabinet that contained: 1) Two bottles of anti-gas (Mi Acid) with an expiration date of 5/2021. 2) Two tubes of bacitracin ointment with expiration dates of 9/2021 and 11/2021. 3) Five containers of cetirizine hydrochloride, an antihistamine, with expiration dates of 11/2021 (2 containers), 12/2021 (1 container) and 6/2021 (2 containers). 4) Two bottles of Geritussin DM, a cough syrup, with expiration dates of 8/2021 and 12/2020. 5) One bottle of liquid Acetaminophen 160mg/5ml that expired 12/2021. 6) Five bottles of extra action cough syrup that expired 11/2021. On 1/6/2022 at 10:17 a.m. an interview was conducted with the Unit Supervisor and she revealed she was unaware of the expired medication in the 500-hall medication room. She reviewed the medication expiration dates and stated she would remove the medication and return it to pharmacy to be destroyed. She revealed she was unaware of the expired medication discovered on the 200-hall cart and stated she would ensure the medication had been removed from the cart. She stated it was the facility policy to remove expired medications and	F 761	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. How correction action will be accomplished for those residents found to have been affected by the deficient practice On 1/6/2022 the nurse removed the expired medication from the 200-hall medication cart and returned it to the pharmacy for destruction. On 1/6/2022 the unit manager removed the expired house stock medications from the 500-hall medication room and returned them to the pharmacy for destruction. How the facility will identify other residents having the potential to be affected by the same deficient practice On 1/6/2022 the unit managers audited all medication carts and medication room house stock cabinets for expired medications. There were no negative findings. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur On 1/7/2022 the director of nursing and unit managers initiated re-education to all nurses and medication aides on	

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F 761	Continued From page 23 place them in the correct area to return to pharmacy for destruction.	F 761	label/store drugs and biologicals, to include removing expired medications from medication storage. All nurses and medication aides, including agency staffing, will be re-educated by 2/11/2022. This education will be part of the orientation process for all newly hired nurses and medication aides, including agency staffing. How the facility plans to monitor its performance to make sure solutions are sustained The director of nursing and/or unit managers will monitor all medication carts and medication rooms for any expired medications that should be removed and returned to the pharmacy for destruction weekly for four weeks and monthly for two months, using the Medication Audit tool, to ensure that there are no expired medications present. Concerns or trends will be reviewed and discussed at the Cardinal Interdisciplinary Team Meeting 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 findings will be given to the Quality Assurance Performance Improvement meeting monthly for three months to determine trends and/or issues that may need further interventions put in place and to determine the need for further and/or frequency of monitoring.	
F 835 SS=K	Administration CFR(s): 483.70	F 835		2/11/22

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F 835	Continued From page 24 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and physician interviews, the facility's administration failed to evaluate the resident population on the memory care unit for the need to have a functional call system in place to alert staff to immediate needs for 8 of 8 (resident #29, #46, #35, #14, #69, #87, #89 and #71) residents with severe to no cognitive impairment that had the physical and cognitive ability to use the call system on the memory care unit (500 and 600 hall). Failure to allow residents to call for assistant in an emergency is likely to cause serious injury, serious harm, or death. Immediate Jeopardy began on 1/2/2022 when it was observed that residents on the memory care unit with the cognitive and physical ability to use the call system did not have a functional call system in the residents' rooms and they did not have an alternate means to call for assistance. The Administrative team (Administrator and Assistant Director of Nursing) were aware the memory care unit did not have a functioning call system. The facility remains out of compliance at a lower scope and severity level of an "E" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to in-service staff who had not received the in-service on 1/5/2022 and ensure monitoring systems put into place are effective.	F 835	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. How correction action will be accomplished for those residents found to have been affected by the deficient practice	

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F 835	Continued From page 25 The findings included: This tag is cross referenced to F919: Based on observation, record review, resident, staff, and physician interviews the facility failed to have a functional call system in place for 8 of 8 (resident #29, #46, #35, #14, #69, #87, #89 and #71) residents who had the physical and cognitive ability to use the call system on the memory care unit (500 and 600 hall). An interview was conducted on 1/4/2022 at 2:50 p.m. with the Assistant Director of Nursing (ADON) and she revealed the call system had not been available on the memory care unit, 500 and 600 halls, during her employment of 17 years. An interview was conducted on 1/4/2022 at 3:25 p.m. with the Administrator and she revealed there had not been a call light system in use on the memory care unit/spark unit, 500 and 600 halls during her employment of 21 years. The Administrator was notified of immediate jeopardy on 1/6/2022 at 2:58 p.m. The facility provided a credible allegation of immediate jeopardy removal dated 1/6/2022. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: Resident #29, #46, #35, #14, #69, #87, #89, and #71 have suffered or are likely to suffer a serious adverse outcome as a result of the noncompliance.	F 835	On 1/4/22, The administrator determined residents #29, #46, #35, #14, #69, #87, #89, and #71 had a functional call light system but did not have the call light cords attached to them. On 1/5/22 The administrator determined the dementia unit residents #29, #46, #35, #14, #69, #87, #89, and #71 have been assessed for and can use a resident call light activation cord/button/mechanism. The administrator ordered and had overnight shipped call light cords for the dementia unit bedrooms. On 1/5/22, the call light cords were installed into the call light system panels in the dementia unit bedrooms for residents #29, #46, #35, #14, #69, #87, #89, and #71. How the facility will identify other residents having the potential to be affected by the same deficient practice On 1/4/22, The administrator determined the dementia unit on 500 and 600 halls had a functional call light system but did not have the call light cords attached to them. On 1/5/22 the administrator determined the dementia unit residents have been assessed for and can use a resident call light activation cord/button/mechanism. The administrator ordered and had overnight shipped call light cords for the dementia unit bedrooms. On 1/5/22, the call light cords were installed into the call light system panels in all bedrooms on the dementia unit. On 1/5/22, the maintenance staff completed a resident call system audit for the entire facility by	

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F 835	Continued From page 26 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. 1. On 1/5/2022 at approximately 2:50 p.m. the Assistant Director of Nursing (ADON), and Unit Managers inserted call light cords into the call light system panels in the residents' bedrooms in the Dementia unit on the 500 and 600 halls. 2. All call lights were tested by the ADON and Unit Managers for proper functioning by seeing the light on, outside the resident room and a chime at the nurse's station. 3. On 1/5/2022 all residents in the Dementia Unit were educated on what a call light is and how to use it. 4. On 1/5/2022 the Administrative staff to include the Administrator and Director of Nursing (DON) were educated by the RN Nurse Consultant on the regulatory requirements for a functioning call light system in the Dementia Unit. 5. On 1/5/2022, the DON, Administrator and Unit Manager initiated pro-active education with all nurses, nursing assistants, department managers, and maintenance staff. The pro-active education emphasized the regulatory requirement for a resident call system and the facility's new practice of providing call light cords in the Dementia unit rooms. The facility alleged the immediate jeopardy removal date was 1/6/2022. Validation of the facility's credible allegation occurred on 1/11/2022 and was evidenced by staff and resident interviews, observation, facility training that included staff ensuring residents had	F 835	seeing a light on outside the resident room and a chime at the nurse's station. The audit findings indicated the call system throughout the facility was functional, including nurse station 1, nurse station 2 and nurse station 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur On 1/5/22, the administrative team inserted call light cords into the call light system panels in the resident bedrooms in the dementia unit rooms on the 500 and 600 halls. On 1/5/22 all residents on the dementia unit were educated on what a call light is and how to use it. On 1/5/22, the director of nursing, administrator and unit manager initiated education with all nurses, nursing assistants, department managers, and maintenance staff. The education emphasized the regulatory requirement for a resident call system and the facility's practice of providing call light cords in the dementia unit rooms and throughout the entire facility in resident care areas. How the facility plans to monitor its performance to make sure solutions are sustained On 1/5/22, the director of nursing, quality initiative nurse, minimum data set nurses, and the unit managers, began audits on the resident call system. The audits include documenting on a Resident Call System audit tool. These audits are	

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F 835	Continued From page 27 a call system within reach in the resident bedrooms on the memory care unit. Observation of the 500 and 600 hall revealed residents had a call light system in place for each room on the 500 and 600 hall. The call light system was observed to be in proper working order. Interviews revealed administrative staff were educated on call system regulatory requirements. The immediate jeopardy was removed on 1/6/2022.	F 835	completed three times a week for one week, one time a week for two weeks, then one time a month for two months. Any missing, incomplete, or incorrect audit findings will be immediately reported to the director of nursing and/or administrator for investigation. Any resident call system concerns and trending will be reviewed and discussed during the Cardinal Interdisciplinary Team Meeting. The resident call system audits will be given to the Quality Assurance Performance Improvement committee monthly for two months to determine trends and/or issues that may need further intervention put in place and to determine the need for further and/or frequency of monitoring, and as needed.	
F 919 SS=K	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, and physician interviews the facility failed to have a functional call system in place for 8 of 8 (resident #29, #46, #35, #14, #69, #87, #89 and #71) residents who had the physical and cognitive ability to use the call system on the memory care unit (500 and 600 hall). Failure to allow residents	F 919	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	2/11/22

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F 919	Continued From page 28 to call for assistant in an emergency is likely to cause serious injury, serious harm, or death. Immediate Jeopardy began on 1/2/2022 when it was observed that residents on the memory care unit with the cognitive and physical ability to use the call system did not have a functional call system in the residents' rooms and they did not have an alternate means to call for assistance. Immediate Jeopardy was removed 1/06/2022 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "E" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to in-service staff who had not received the in-service on 1/5/2022 and ensure monitoring systems put into place are effective. The findings included: On 1/2/2022 at 12:27 PM an observation was conducted of Resident #87 and #14's room. The call light system was observed with two end cap pieces inserted in the location where a call light would be located. Resident #87 was observed walking out of the bathroom with a walker, independently, then walking to the sink, washing her hands, and drying them independently. On 1/2/2022 at 12:27 PM an interview was conducted with Resident #87 and she revealed that she had to yell for help when she desired assistance from staff. She stated when she was able, she walked to the nursing station for help. Resident #87's quarterly MDS dated 11/18/2021 revealed Resident #87 had severe cognitive	F 919	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. How correction action will be accomplished for those residents found to have been affected by the deficient practice On 1/4/22, The administrator determined residents #29, #46, #35, #14, #69, #87, #89, and #71 had a functional call light system but did not have the call light cords attached to them. The administrator ordered and had overnight shipped call light cords for the dementia unit bedrooms. On 1/5/22, the call light cords were installed into the call light system panels in the dementia unit bedrooms for residents #29, #46, #35, #14, #69, #87, #89, and #71. How the facility will identify other residents having the potential to be affected by the same deficient practice	

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F 919	Continued From page 29 impairment, was able to communicate needs, and usually understood others. On 1/2/2022 at 12:30 PM an interview was conducted with Resident #14 and she revealed that when she needed assistance she must yell for help or walk to the nursing station. She stated that at night she sometimes did not have the strength to walk to the station and had to wait for staff to come around, an hour or so for help. She stated she knows how to use a call bell to call for help, you press the button. Resident #14 pointed to her pants around her thighs as she was observed sitting on the edge of the bed and stated she would call for assistance with a bell at that time if one was available to ask for help to pull her pants up. On 1/2/2022 at 12:41 PM An observation was conducted as Resident #14 worked to pull her pants up without assistance with her back on the bed, lying down, and her legs off the bed using back and forth motions. Resident #14's significant change MDS dated 10/1/2021 revealed Resident #14 had moderate cognitive impairment, was able to communicate her needs with no documentation of inattention or disorganized thinking. 1/4/2022 at 9:01 a.m. an observation was conducted of each room on the 500 and 600 hall and a call light was not available at the bedside for the unit, which included rooms for Resident #29, #46, #35, #14, #69, #87, #89 and #71. 1/4/2022 at 9:08 a.m. an interview was conducted with Resident #35 and she revealed if she needed help, she had to get into her wheelchair	F 919	On 1/4/22, The administrator determined the dementia unit on 500 and 600 halls had a functional call light system but did not have the call light cords attached to them. The administrator ordered and had overnight shipped call light cords for the dementia unit bedrooms. On 1/5/22, the call light cords were installed into the call light system panels in all bedrooms on the dementia unit. On 1/5/22, the maintenance staff completed a resident call system audit for the entire facility by seeing a light on outside the resident room and a chime at the nurse's station. The audit findings indicated the call system throughout the facility was functional, including nurse station 1, nurse station 2 and nurse station 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur On 1/5/22, the administrative team inserted call light cords into the call light system panels in the resident bedrooms in the dementia unit rooms on the 500 and 600 halls. On 1/5/22 all residents on the dementia unit were educated on what a call light is and how to use it. On 1/5/22, the director of nursing, administrator and unit managers initiated education with all nurses, nursing assistants, department managers, and maintenance staff. The education emphasized the regulatory requirement for a resident call system and the facility's practice of providing call light cords in the dementia unit rooms and	

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F 919	Continued From page 30 and roll up the hall to find someone to ask for help because she had no other way to ask for help. Resident #35's quarterly MDS dated 10/13/2021 revealed Resident #35 had moderate cognitive impairment with moderate hearing difficulty, clear speech, could make herself understood and understood other people. An interview was conducted on 1/4/2022 at 9:25 a.m. with Resident #46 and she stated when she needs help she yells. She added it does not bother her to yell for help but other residents yell for her to stop yelling. Resident #46's quarterly MDS dated 12/14/2021 revealed resident #46 was cognitively intact for decision making, had moderate difficulty hearing without a hearing aid, was able to make self understood and usually understood others with adequate vision. On 1/4/2022 at 9:28 a.m. Resident #46 was asked how she calls for assistance. Resident #46 replied that she yells. At this time Resident #29 replied, "I wish she (Resident #46) had a way to call for help so she would hush." Resident #29's Minimum Data Set (MDS) dated 10/8/2021 revealed Resident #29 was cognitively intact for decision making, had adequate hearing and vision, with clear speech and was able to make herself understood for communication. 1/4/2022 at 1:46 PM an interview was conducted with Resident #69 and he revealed he had to yell for help anytime he required help. He stated he yells, "help, help, help." He added that three days	F 919	throughout the entire facility in resident care areas. How the facility plans to monitor its performance to make sure solutions are sustained On 1/5/22, the director of nursing, quality initiative nurse, minimum data set nurses, and the unit managers began audits on the resident call system. The audits include documenting on a Resident Call System audit tool. These audits are completed three times a week for one week, one time a week for two weeks, then one time a month for two months. Any missing, incomplete, or incorrect audit findings will be immediately reported to the director of nursing and/or administrator for investigation. Any resident call system concerns and trending will be reviewed and discussed during the Cardinal Interdisciplinary Team Meeting. The Resident Call System audits will be given to the Quality Assurance Performance Improvement committee monthly for two months to determine trends and/or issues that may need further intervention put in place and to determine the need for further and/or frequency of monitoring, and as needed.	

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F 919	Continued From page 31	F 919		

prior he had to use the bathroom in the bed. He stated he yelled for assistance and no one could hear him yelling because he was at the end of the hall and all of the others yell for help. He added the staff cannot hear him over the others. He revealed he had felt too weak and could not get to the restroom and no staff came to help. He stated he knows how to use a call bell, but one was not available. He stated you press the button.

Resident #69's quarterly MDS dated 11/9/2021 revealed Resident #69 had moderate cognitive impairment, was able to communicate his needs and usually understood others.

Resident #89's annual MDS dated 11/19/2021 revealed Resident #89 had cognitive impairment but was able to communicate her needs and understand others.

Resident #71's quarterly (MDS) dated 11/11/2021 revealed Resident #71 had unclear speech, was usually understood, and usually understood others with severe cognitive impairment and fluctuating disorganized thinking.

On 1/4/2022 at 1:52 PM an interview was conducted with Nursing Assistant (NA) #1 and she revealed call lights had not been used on the 500 and 600 halls since she had been employed with the facility. She stated the staff anticipate the residents needs and make regular rounds every 2 hours. She stated residents that can, will yell out or walk to the staff to make their needs known. She revealed a few residents on the unit had the ability to use a call light system if this was available and had incontinent episodes between rounds that could be prevented if a call light was available.

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On 1/4/2022 at 1:56 PM an interview was conducted with NA #2 and she revealed a call light system had not been used on the 500 and 600 hall since she had been employed with the facility. She revealed she does a round before breakfast and after, then a check before lunch. She does a round again after lunch and then another check before she goes home at 3:00 PM with as needed care. She added there were a few residents that had the ability to use a call light.

On 1/4/2022 at 2:21 PM an interview was conducted with Nurse #1 and she revealed that call lights had not been used on the 500 and 600 hall memory care unit and the facility used hourly rounding in the place of call lights. She stated Resident #46 yells for assistance. She stated Resident #87 and #35 walk independently to the nursing station to request staff assistance. She revealed Resident #35 had an unwitnessed fall in her room and had to yell out for assistance until someone heard her. She revealed resident #29, #46, #35, #14, #69, #87, #89 and #71 had the cognitive ability to communicate their needs to staff.

An interview was conducted on 1/4/2022 at 2:50 PM with the Assistant Director of Nursing and she revealed the call light system had not been available on the memory care unit, 500 and 600 halls, during her employment. She stated this was a decision made prior to her employment for the safety of the resident population on this unit. She revealed the residents with higher cognition call for assistance by walking or wheeling/locomoting to ask for help from staff. She revealed no alternative call bell systems were in use on the unit.

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 01/11/2022

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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An interview was conducted on 1/4/2022 at 3:25 p.m. with the Administrator and she revealed there had never been a call light system in use on the memory care unit, 500 and 600 halls. She stated the risk outweighs the benefit for the population on the unit. When asked what the risk were, she stated long cords. She revealed the staff conduct rounds and meet the anticipated needs of the residents on the unit.

On 1/5/2022 at 10:55 AM an interview was conducted with the Medical Director and he revealed that he felt there were residents on the memory care unit that he would not question their ability to use the call light.

The Administrator was notified of immediate jeopardy on 1/6/2022 at 2:58 p.m.

The facility provided a credible allegation of immediate jeopardy removal dated 1/6/2022.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and Residents #29, #46, #35, #14, #69, #87, #89, and #71, have suffered or are likely to suffer a serious adverse outcome as a result of the non-compliance.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

1. On 1/5/2022 at approximately 2:50 p.m. the Assistant Director of Nursing (ADON), the Unit Managers inserted call light cords into the call light system panels in the resident's bedrooms in

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the Dementia unit on the 500 and 600 halls.
2. All call lights were tested by the ADON and Unit Managers for proper functioning by seeing the light on outside the resident room and a chime at the nurse's station.
3. On 1/5/22 all residents on the Dementia Unit were educated on what a call light is and how to use it.
4. On 1/5/22, the Director of Nursing (DON), Administrator and Unit Manager initiated pro-active education with all nurses, nursing assistants, department managers, and maintenance staff. The pro-active education emphasized the regulatory requirement for a resident call system and the facility's new practice of providing call light cords in the Dementia unit rooms.

The facility alleged the Immediate Jeopardy removal date was 1/6/2022.

Validation of the facility's credible allegation occurred on 1/11/2022 and was evidenced by staff and resident interviews, observation, facility training that included staff ensuring residents had a call system within reach in the resident bedrooms on the memory care unit. Observation of the 500 and 600 hall revealed residents had a call light system in place for each room on the 500 and 600 halls. The call light system was observed to be in proper working order. The immediate jeopardy was removed on 1/6/2022.