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 03/28/2019

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 on 3/24/19 to 3/28/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LHYC11.	E 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) 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	F 580		4/25/19

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

Electronically Signed | 04/19/2019

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 03/28/2019

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 580	Continued From page 1 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 record review, and staff, and Nurse Practitioner (NP) interview the facility failed to notify the provider of signs and symptoms of infections in wound assessments and failed to notify the provider of the facility ' s audit that revealed inaccurate transcription of treatment orders for 1 of 5 (Resident #32) reviewed for pressure ulcers. Findings include: Resident #32 was originally admitted to the facility on 6/25/15 with the diagnoses of Alzheimer ' s disease, chronic pain, and dysphagia. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated for 1/4/19 revealed that Resident #32 was cognitively impaired, incontinent of bladder and bowel,	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 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	

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 03/28/2019

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 580	Continued From page 2 required one to two-person extensive to total assistance for all activities of daily living (ADLs), and that she had one stage 4 pressure ulcer. Review of Resident #32 ' s Care Plan revealed a plan was initiated on 10/4/18 for ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: immobility, nutritional deficit Stage IV Pressure to Sacrum. Interventions included: ensure appropriate pressure relieving devices in place during repositioning, follow facility protocol/ regime for treating breaks in skin integrity/ pressure ulcers for STAGE: IV SITE: Sacrum, observe skin daily during care for any changes. Report any abnormal observations to nurse, obtain labs as ordered and notify physician of results, and supplements as ordered by physician. Review of skin assessment ' s revealed that Resident #32 did not have pressure ulcers before 10/3/18 and a stage 2 pressure ulcer on the sacrum was assessed and documented in a wound assessment on 10/3/18. The NP ordered a treatment order for Nurse practitioner assessed the wound on 10/3/18 and it was red. The NP ordered to cleanse the sacrum with NS, apply hydrocolloid, change every 7 days (Wednesday) and PRN every day for wound healing. The facility also had initiated pressure reducing devices in wheelchair and bed. Review of a wound assessment on 10/25/18 revealed the wound became unstageable had some necrosis and exudate. The treatment order was changed. The drainage was scant yellow. It was 80% pink granulation, 10% black eschar,	F 580	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 4/19/19 the Nurse Practitioner (NP) visited Resident #32 and documented on her sacrum wound. On 4/19/19 the NP updated sacrum wound treatment orders. On 4/18/19 the Director of Nursing (DON) and the Treatment Nurse reviewed all residents with wounds to ensure that provider had notification and provider prescribed orders were being carried out as ordered. On 4/18/19 the Staff Facilitator (SF) initiated re-education to all licensed nursing staff, including agency staff, on notification of changes in condition to MD/NP/RR, including changes in wounds, wound assessments and transcribing orders. By 4/27/19 all licensed nursing staff, newly hired licensed nursing staff, including agency staff, will be re-educated by the SF on notification of changes in condition to MD/NP/RR, to include changes in wounds, wound assessments and transcribing orders. This education will be part of the orientation process for all newly hired licensed nursing staff, including agency staff. The facility Interdisciplinary Team (IDT) members will review in daily clinical	

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 03/28/2019

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 580	Continued From page 3 10% yellow slough A new physician order was placed on 10/26/2018 to cleanse the sacrum with NS, apply silver collagen, gauze and allevyn foam dressing, change daily and PRN as needed for wound healing. Review of a wound assessment from 11/1/18 revealed that Resident #32 ' s wound was 50% yellow slough and 50 % black Eschar. Wound treatment order was placed on 11/2/2018 for Santyl Ointment 250 UNIT/GM (Collagenase) apply to sacrum topically every day shift for wound healing Cleanse sacrum with NS, apply santyl, gauze and allevyn foam border dressing daily. Resident #32 was sent to the hospital on 11/20/18 for a dislocated hip. During her hospital stay, a plastic surgeon debrided the wound and recommended the resident to go to wound care specialist within 3 weeks of discharge. The resident returned to the facility on 11/29/18. Review of a wound assessment from 11/29/18, the wound was undermining and tunneling and it became a stage 4 with new orders placed to cleanse sacrum with normal saline, apply santyl, wet to dry gauze and allevyn foam border dressing daily. Review of consult notes revealed resident #32 was sent to the wound clinic on 12/28/18 (the first available appointment). The wound clinic recommended to change the order to Dakins Solution 0.125 % Apply to Sacrum topically every day shift for Wound Healing Irrigate wound and pat dry. Lidocaine Gel apply to Sacral wound	F 580	meeting the progress notes dated from previous to current meeting to determine potential changes of conditions in resident conditions to include notification of provider and Resident Representative (RR). 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 (QA) Committee monthly for 3 months and as needed. The IDT is responsible for the Plan of Correction and the DON is responsible for sustained compliance.	

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 03/28/2019

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 580	Continued From page 4	F 580		

topically every day shift for Wound healing.

A physician order was placed on 2/13/19 for Dakins Solution 0.125 % - Apply to Sacrum topically every day shift for Wound Healing Irrigate wound and pat dry.

A physician order was placed on 2/16/19 for Lidocaine Gel 2 % - Apply to Sacral wound topically every day shift for Wound healing

During an interview with Nurse Practitioner (NP) on 3/28/19 at 12:35 PM she stated that Resident #32 she assessed the wounds about once a month but speaks with the treatment nurse at least weekly for wound updates on Resident #32. She stated that when she first assessed the wound in the beginning, it had started as a stage 2 pressure ulcer and was red then went from redness to a stage 3/unstageable with lots of exudate, slough, and tunneling very quickly and placed orders for debridement with the Santyl and stated that it was debriding slowly. She wanted staff to keep the resident in the bed more because sitting in her wheelchair was hard on her sacrum because she is very bony and skinny. She ordered supplements to increase protein with meals. The resident was resistant with care and doesn ' t always eat/drink her supplements to improve her weight issues. When asked about her routine assessments and the lack of documentation she stated that she doesn ' t always document the wounds and usually does only if there is a change in the wound. When the NP was asked to review a few of the resident ' s assessments with this surveyor, she stated that the documentation was not accurate. That if she had been informed of a foul odor and purulent drainage, she would have started an antibiotic.

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 03/28/2019

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 580	Continued From page 5 She stated that she was not informed of Resident #32 having purulent drainage or having any foul odor by the treatment nurse or other staff members. She stated that it was her expectation that staff report to her any signs and symptoms of infection so that it can be assessed and treated appropriately. During an interview with the NP on 3/28/19 at 3:48 PM she stated that she was not informed that the resident was not receiving the correct dressing from the time the resident had the wound consult recommendations on 12/28/18. She stated that she was informed of the new orders that were recommended and had told the treatment nurse to initiate the order recommended by the wound specialist. She stated that she was under the impression that those orders had been in place and was not aware that they were not actually started until 2/13/19 and 2/16/19. Attempts were made to interview the previous treatment nurse on 3/28/19 but no interview was obtained. During an interview with the Administrator on 3/28/19 at 4:45 PM she stated that the facility had found problems with documentation and order transcription after the former treatment nurse had left. An audit was performed, and the facility had found that Resident #32 had not had the correct treatment orders in place, so it was corrected on 2/13/19. She stated that it was her expectation that staff report signs and symptoms of infection the provider, follow orders placed, and to document accurate assessments of wounds.	F 580		
F 656	Develop/Implement Comprehensive Care Plan	F 656		4/25/19

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 03/28/2019

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 656 SS=D	Continued From page 6 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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 03/28/2019

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 656	Continued From page 7 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop a care plan that addressed discharge goals and plans for 1 of 1 resident (Resident #201) reviewed for discharge to the community. Findings included: Resident #201 was admitted to the facility on 2/9/18 with diagnoses that included, in part, hypertension, diabetes mellitus and cerebrovascular accident. Resident #201 discharged home on 6/1/18. A review of the admission Minimum Data Set (MDS) assessment dated 2/16/18 revealed Resident #201 was cognitively intact. Further review of the MDS assessment revealed Resident #201 expected to be discharged back to the community. A review of the care plan updated 5/1/18 revealed there was no care plan that addressed discharge planning. On 3/27/19 at 5:12 PM an interview was completed with MDS Nurse #1. She stated the facility included discharge planning on the comprehensive care plan in February 2018. She said a discharge care plan should have been included on Resident #201's comprehensive care plan and thought it was an oversight that it had not been completed.	F 656	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 3/28/19 the facility IDT reviewed the care plan for Resident #201. Resident #201 no longer resides at the facility. On 3/27/19 □ 3/30/19 both Minimum Data Set (MDS) Nurses reviewed 100% of care plans to ensure that all care plans have a discharge planning focus problem. The	

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 03/28/2019

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 656	Continued From page 8 On 3/28/19 at 5:07 PM an interview was completed with the Administrator. She stated she expected discharge plans and goals be included in a resident's comprehensive care plan.	F 656	MDS Nurses and Social Services revised care plans immediately. On 3/29/19 Registered Nurse Consultant re-educated MDS Nurses and Social Services to include initiating a discharge planning focus problem at the time of admission, i.e. on the initial baseline care plan. Any newly hired MDS Nurse and/or Social Services will receive education by the SF through the orientation process. The MDS Nurse and/or designee will review all new admission and readmission baseline care plans to ensure that discharge plans are included on care plans for 3 months and as needed. The MDS Nurse and/or designee will review 10% of all comprehensive care plans to ensure that discharge plans are addressed on each care plan for 3 months and as needed. The Compliance Monitoring Tool will be utilized. All results of audits will be presented in monthly QA meeting and as needed. Immediate action and/or education will be completed if any areas are identified. Results will be brought to IDT meeting on going and to the monthly QA meeting monthly for 3 months and as needed. The IDT members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.	

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 03/28/2019

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 657	Continued From page 9	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interview, the facility failed to revise the Care Plan for 1 of 2 residents (Resident #106) who required the total assistance of two staff for bed mobility and was dependent on the use of a carefoam chair for mobility.	F 657	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	4/25/19

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 03/28/2019

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 657	Continued From page 10 Findings included: Resident #106 was admitted to the facility on 12/21/98 with diagnoses which included: Functional quadriplegia, cerebral infarction, muscle weakness, abnormal posture, lack of coordination, peripheral vascular disease, vascular dementia, epilepsy, and other malaise. Review of Occupational Therapy's Plan of Care dated 8/31/18 indicated Resident #106 was assessed for positioning in a carefoam chair (specialty chair) with pillows placed to accommodate the resident's range of motion limitations. The quarterly MDS (minimum data set) dated 2/11/19 indicated Resident #106 was severely, cognitively impaired; was totally dependent of two staff for bed mobility and transfers; was totally dependent of one staff for locomotion on the unit; and had impaired range of motion of bilateral upper and lower extremities. A review of the Care Plan dated 2/25/19 revealed the interventions for the activities of daily living/personal care of Resident #106 included: one person to assist the resident with bed mobility; and the use of a broda chair as a mobility device for the resident. During an observation on 3/25/19 at 10:33 a.m., Resident #106 was reclining in a carefoam chair on wheels in the hallway near the nursing station. During an interview on 3/27/19 at 10:00 a.m., the Rehabilitative Manager indicated Resident #106 had the use of the carefoam chair for positioning	F 657	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 3/27/19 the MDS Nurse reviewed the care plan of Resident #106 and revised as necessary. On 4/18/19 both MDS Nurses reviewed a 100% of care plans and revised immediately as necessary to ensure appropriate assistance is provided to residents. On 4/18/19 the Administrator re-educated both MDS Nurses to include reviewing and revising care plans timely, including both the comprehensive and quarterly assessments. Any newly hired MDS Nurse will receive education by the SF during the orientation process. The MDS Nurse and/or designee will review 10% of all care plans to ensure appropriate assistance is provided to	

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 03/28/2019

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 657	Continued From page 11 because she was unable to be positioned comfortably in other mobility chairs. During an interview on 3/27/19 at 4:19 p.m., after reviewing Resident #106's ADL (activities of daily living) assessment documentation, the MDS Coordinator revealed that during the look back period of the most recent MDS, the resident required a two person assist with bed mobility on two occasions. During the other times of the assessment, the resident required the assistance of one staff. She stated the Care Plan should have been updated to include the resident required a one to two person assist with bed mobility. The MDS Coordinator also stated that the broda chair was incorrectly documented in the ADL section of the Care Plan as the resident's mobility device. She revealed the mobility device currently used by the resident was the carefoam chair.	F 657	residents monthly for 3 months and as needed. The Compliance Monitoring Tool will be utilized. All results of audits will be presented in monthly QA meeting for 3 months and as needed. Immediate action and/or education will be completed if any areas are identified. The IDT Members are responsible for the Plan of Correction and the Administrator is responsible for sustained compliance.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		4/25/19

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 03/28/2019

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 686	Continued From page 12 by: Based on record review, and staff, and Nurse Practitioner (NP) interviews the facility failed to implement treatment orders as prescribed by the provider for 1 of 5 (Resident #32) reviewed for pressure ulcers. Findings include: Resident #32 was originally admitted to the facility on 6/25/15 with the diagnoses of Alzheimer ' s disease, chronic pain, and dysphagia. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated for 1/4/19 revealed that Resident #32 was cognitively impaired, incontinent of bladder and bowel, required one to two-person extensive to total assistance for all activities of daily living (ADLs), and that she had one stage 4 pressure ulcer. Review of Resident #32 ' s Care Plan revealed a plan was initiated on 10/4/18 for ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: immobility, nutritional deficit Stage IV Pressure to Sacrum. Interventions included: ensure appropriate pressure relieving devices in place during repositioning, follow facility protocol/ regime for treating breaks in skin integrity/ pressure ulcers for STAGE: IV SITE: Sacrum, observe skin daily during care for any changes. Report any abnormal observations to nurse, obtain labs as ordered and notify physician of results, and supplements as ordered by physician. Review of skin assessment ' s revealed that Resident #32 did not have pressure ulcers before 10/3/18 and a stage 2 pressure ulcer on the sacrum was assessed and documented in a wound assessment on 10/3/18. The NP ordered a treatment order for Nurse practitioner assessed the wound on	F 686	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 4/19/19 the NP visited Resident #32 and documented on her sacrum wound. On 4/19/19 the NP updated sacrum wound treatment orders. On 4/18/19 the DON and the Treatment Nurse reviewed all residents with wounds to ensure that provider had notification and provider prescribed orders were being carried out as ordered. On 4/18/19 the SF initiated re-education to all licensed nursing staff, including	

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 03/28/2019

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 686	Continued From page 13 10/3/18 and it was red. The NP ordered to cleanse the sacrum with NS, apply hydrocolloid, change every 7 days (Wednesday) and PRN every day for wound healing. The facility also had initiated pressure reducing devices in wheelchair and bed. Review of a wound assessment on 10/25/18 revealed the wound became unstageable had some necrosis and exudate. The treatment order was changed. The drainage was scant yellow. It was 80% pink granulation, 10% black eschar, 10% yellow slough A new physician order was placed on 10/26/2018 to cleanse the sacrum with NS, apply silver collagen, gauze and allevyn foam dressing, change daily and PRN as needed for wound healing. Review of a wound assessment from 11/1/18 revealed that Resident #32 ' s wound was 50% yellow slough and 50 % black Eschar. Wound treatment order was placed on 11/2/2018 for Santyl Ointment 250 UNIT/GM (Collagenase) apply to sacrum topically every day shift for wound healing Cleanse sacrum with NS, apply santyl, gauze and allevyn foam border dressing daily. Resident #32 was sent to the hospital on 11/20/18 for a dislocated hip. During her hospital stay, a plastic surgeon debrided the wound and recommended the resident to go to wound care specialist within 3 weeks of discharge. The resident returned to the facility on 11/29/18. Review of a wound assessment from 11/29/18, the wound was undermining and tunneling and it became a stage 4 with new orders placed to cleanse sacrum with normal saline, apply santyl, wet to dry gauze and allevyn foam border dressing daily. Review of consult notes revealed resident #32	F 686	agency staff, on notification of changes in condition to MD/NP/RR, to include changes in wounds, wound assessments and transcribing orders. By 4/25/19 all licensed nursing staff, newly hired licensed nursing staff and agency staff will be re-educated by the SF on notification of changes in condition to MD/NP/RR, to include changes in wounds, wound assessments and transcribing orders. This education will be part of the orientation process for all newly hired licensed nursing staff, including agency staff. The DON will perform weekly wound rounds with the Treatment Nurse to ensure that all provider prescribed treatment orders are implemented as ordered. The Compliance Monitoring Tool will be utilized. 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 QA Committee monthly for 3 months and as needed. The IDT is responsible for the Plan of Correction and the DON is responsible for sustained compliance.	

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 03/28/2019

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 686	Continued From page 14	F 686		

was sent to the wound clinic on 12/28/18 (the first available appointment). The wound clinic recommended to change the order to Dakins Solution 0.125 % Apply to Sacrum topically every day shift for Wound Healing Irrigate wound and pat dry. Lidocaine Gel apply to Sacral wound topically every day shift for Wound healing.
A physician order was placed on 2/13/19 for Dakins Solution 0.125 % - Apply to Sacrum topically every day shift for Wound Healing Irrigate wound and pat dry.
A physician order was placed on 2/16/19 for Lidocaine Gel 2 % - Apply to Sacral wound topically every day shift for Wound healing
During an interview with Nurse Practitioner (NP) on 3/28/19 at 12:35 PM she stated that Resident #32 she assessed the wounds about once a month but speaks with the treatment nurse at least weekly for wound updates on Resident #32. She stated that when she first assessed the wound in the beginning, it had started as a stage 2 pressure ulcer and was red then went from redness to a stage 3/unstageable with lots of exudate, slough, and tunneling very quickly and placed orders for debridement with the Santyl and stated that it was debriding slowly. She wanted staff to keep the resident in the bed more because sitting in her wheelchair was hard on her sacrum because she is very bony and skinny. She ordered supplements to increase protein with meals. The resident was resistant with care and doesn ' t always eat/drink her supplements to improve her weight issues. When asked about her routine assessments and the lack of documentation she stated that she doesn ' t always document the wounds and usually does only if there is a change in the wound. When the NP was asked to review a few of the resident ' s assessments with this surveyor, she stated that

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 03/28/2019

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 686	Continued From page 15 the documentation was not accurate. That if she had been informed of a foul odor and purulent drainage, she would have started an antibiotic. She stated that she was not informed of Resident #32 having purulent drainage or having any foul odor by the treatment nurse or other staff members. She stated that it was her expectation that staff report to her any signs and symptoms of infection so that it can be assessed and treated appropriately. During an interview with the NP on 3/28/19 at 3:48 PM she stated that she was not informed that the resident was not receiving the correct dressing from the time the resident had the wound consult recommendations on 12/28/18. She stated that she was informed of the new orders that were recommended and had told the treatment nurse to initiate the order recommended by the wound specialist. She stated that she was under the impression that those orders had been in place and was not aware that they were not actually started until 2/13/19 and 2/16/19. Attempts were made to interview the previous treatment nurse on 3/28/19 but no interview was obtained. During an interview with the Administrator on 3/28/19 at 4:45 PM she stated that the facility had found problems with documentation and order transcription after the former treatment nurse had left. An audit was performed, and the facility had found that Resident #32 had not had the correct treatment orders in place, so it was corrected on 2/13/19. She stated that it was her expectation that staff report signs and symptoms of infection the provider, follow orders placed, and to document accurate assessments of wounds.	F 686		
F 759	Free of Medication Error Rts 5 Prcnt or More	F 759		4/25/19

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 03/28/2019

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 759 SS=D	Continued From page 16 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 4 medication errors out of 27 medication opportunities, resulting in a medication error rate of 14.8% for 3 of 10 residents (Resident #82, Resident #107, and Resident #58) observed during medication pass. The findings included: 1) Resident #82 was admitted to the facility on 2/29/16. Her cumulative diagnoses included diabetes, Stage 3 (moderate) chronic kidney disease, and cognitive communication deficit. On 3/25/19 at 4:25 PM, Nurse #1 was observed as she checked Resident #82 ' s blood glucose (blood sugar). The resident ' s blood glucose level was 242 milligram/deciliter (mg/dl). After the blood glucose check was completed, the nurse reviewed the sliding scale insulin regimen on the resident ' s electronic Medication Administration Record (MAR) to determine how many units of insulin needed to be injected based on the blood glucose result obtained. Nurse #1 was then observed as she prepared and injected 2 units of Novolog insulin (a rapid acting insulin) subcutaneously (SQ) for Resident #82.	F 759	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 3/25/19 Charge Nurse notified provider of Insulin administration dose and obtained clarification orders on Insulin Sliding Scale for Resident #82.	

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 03/28/2019

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 759	Continued From page 17 A review of Resident #82 ' s medication orders included a physician ' s verbal order dated 1/28/19 for Novolog sliding scale insulin to be administered utilizing the following parameters: If blood glucose level is 150-200 = administer 2 units insulin; If blood glucose level is 201-250 = administer 4 units insulin; If blood glucose level is 251-300 = administer 6 units insulin; If blood glucose level is 301-350 = administer 8 units insulin, If blood glucose level is 351-400 = administer 10 units insulin; If blood glucose level is 401-450 = administer 12 units insulin. An interview was conducted on 3/25/19 at 4:45 PM with Nurse #1. Upon request, the nurse reviewed the sliding scale insulin regimen on Resident #82 ' s MAR. The blood glucose/insulin parameters listed on the MAR indicated: If blood glucose level is 150-200 = administer 1 unit insulin; If blood glucose level is 201-250 = administer 2 units insulin; If blood glucose level is 251-300 = administer 3 units insulin; If blood glucose level is 301-350 = administer 4 units insulin, If blood glucose level is 351-400 = administer 5 units insulin; If blood glucose level is 401-450 = administer 6 units insulin; Call Medical Doctor (MD) if blood glucose is greater than 451. Nurse #1 reported that based on the resident ' s MAR, the amount of Novolog insulin administered to the resident (2 units for a blood glucose of 242	F 759	On 3/27/19 Charge Nurse notified provider of Creon DR administration time for Resident #107. No new orders given. On 3/29/19 Charge Nurse notified provider of the medication administration and obtained orders to discontinue medications that cannot be crushed and obtained medications that can be crushed for Resident #58. On 3/25/19 the IDT Members reviewed all residents receiving insulin. No negative findings noted and no new orders received. On 4/18/19 the IDT Members reviewed all residents in need of crushed medication administration and residents receiving Creon DR, notified provider and obtained orders as necessary. On 4/18/19 the SF initiated re-education to all licensed nursing staff and medication aides, including agency staff, to include the Seven Rights of Medication Administration. By 4/25/19 all licensed nursing staff and medication aides, including newly hired licensed nursing staff and medication aides, including agency staff, will be re-educated by the SF to include the Seven Rights of Medication Administration. This education will be part of the orientation process for all newly hired licensed nursing staff and medication aides, including agency staff.	

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 03/28/2019

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 759	Continued From page 18 mg/dl) was correct. Upon her request, an interview was conducted on 3/25/19 at 5:00 PM with Nurse #1. During the interview, the nurse stated she had requested and received MD clarification of Resident #82 ' s sliding scale insulin order. She reported the resident was supposed to receive 4 units of insulin during the medication administration observed and stated the resident was given the additional 2 units of Novolog insulin (for a total of 4 units). The nurse reported for some reason the correct sliding scale insulin order had not carried over onto the resident ' s MAR. An interview was conducted on 3/28/19 at 4:05 PM with the facility ' s Administrator and Director of Nursing (DON). During the interview, the facility ' s medication errors and medication error rate were discussed. When asked, the Administrator stated she would expect the nurses to follow the facility ' s med administration policies and procedures. 2) Resident #107 was admitted to the facility on 7/30/18. His cumulative diagnoses included chronic pancreatitis. A review of Resident #107 ' s most recent annual Minimum Data Set (MDS) assessment dated 2/11/19 revealed the resident had intact cognitive skills for daily decision making. On 3/27/19 at 8:40 AM, Medication Aide (Med Aide) #1 was observed as she prepared medications for administration to Resident #107. The medications included one-36,000 units capsule of Creon Delayed Release (DR). Creon DR is a medication which contains a combination of digestive enzymes that act locally in the small	F 759	Facility Pharmacist and the DON 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. All results of audits will be presented in monthly QA meeting for 3 months and as needed. Immediate action and/or education will be completed if any areas are identified. The IDT Members are responsible for the Plan of Correction and the DON is responsible for sustained compliance.	

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 03/28/2019

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 759	Continued From page 19	F 759		

intestine to aid in the digestion of fats, protein, and starches. Creon is used to replace these enzymes when the body does not have enough of its own. Product information from the manufacturer indicated because of the local action of this medication, Creon must be taken with food in order for the medication to work.

On 3/27/19 at 8:45 AM, Med Aide #1 entered Resident #107 ' s room to administer his medications. Upon entering his room, Med Aide #1 asked the resident, "Did you eat all that breakfast?" The resident responded by saying that he did. His meal tray was not in his room at the time of the observation. Med Aide #1 was then observed as she administered the resident ' s medications, which included the Creon DR capsule.

An interview was conducted on 3/27/19 at 8:46 AM with Resident #107. During the interview, the resident reported he ate a good breakfast. When asked, the resident reported his breakfast came to his room at about 7:30 AM this morning and he ate the meal when it was delivered to him. Upon further inquiry, the resident confirmed he had eaten his breakfast at least an hour prior to the med pass observation.

An interview was conducted on 3/27/19 at 8:55 AM with Nursing Assistant (NA) #1. NA #1 was observed to be collecting dirty breakfast trays from the rooms on Resident #107 ' s hall earlier that morning. During the interview, the NA was asked when the hall breakfast trays were delivered to the floor and served to the residents that morning. She stated the trays came out to the hall that morning around 7:30 AM and the trays were served shortly after that time.

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 03/28/2019

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 759	Continued From page 20	F 759		

A review of Resident #107 ' s physician ' s orders included a current medication order for 36,000 units Creon DR to be given as one capsule by mouth before meals (initiated on 8/2/18). The Creon DR was scheduled for administration three times daily at 8:00 AM, 12:00 PM, and 5:00 PM.

An interview was conducted on 3/27/19 at 1:25 PM with Med Aide #1. During the interview, the Med Aide reviewed the instructions on Resident #107's MAR for the administration of Creon DR. Upon review, the Med Aide reported she was not aware the medication needed to be given before the meal. She acknowledged the Creon DR was administered more than 1 hour after Resident #107 ' s breakfast meal. The Med Aide stated she may need to start her morning med pass at Resident #107's end of the hall to ensure the med was administered right before his meal.

An interview was conducted on 3/28/19 at 4:05 PM with the facility ' s Administrator and Director of Nursing (DON). During the interview, the facility ' s medication errors and medication error rate were discussed. When asked, the Administrator stated she would expect the nurses to follow the facility ' s med administration policies and procedures.

3) Resident #58 was admitted to the facility on 3/3/16. Her cumulative diagnoses included Stage 4 chronic kidney disease, hypertension, and acute on chronic diastolic (congestive) heart failure.

On 3/27/19 at 9:28 AM, Medication Aide (Med Aide) #2 was observed as she prepared medications for administration to Resident #58.

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 03/28/2019

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 759	Continued From page 21	F 759		

The medications included one tablet of 100 milligrams (mg) metoprolol succinate Extended Release (an antihypertensive medication) and one tablet of 30 mg isosorbide mononitrate Extended Release (a medication used to prevent angina or chest pain). Both tablets were observed to be crushed and administered in applesauce to Resident #58.

A review of Resident #58 ' s current medication orders included:
--100 mg metoprolol succinate Extended Release (ER) to be given as one tablet by mouth in the morning, with a notation which read in capital letters, "Do not crush."
--30 mg isosorbide mononitrate ER to be given as one tablet by mouth in the morning, with a notation which read in capital letters, "Do not crush."

According to Lexi-Comp, a comprehensive on-line medication database, neither metoprolol succinate ER tablets nor isosorbide mononitrate ER tablets should be crushed for administration.

An interview was conducted with Med Aide #2 on 3/27/19 at 10:15 AM. Upon review of Resident #58 ' s MAR for metoprolol succinate ER and isosorbide mononitrate ER, the med aide noted the administration instructions on the MAR indicated these tablets were not to be crushed. She stated, "And I crushed them." Med Aide #2 acknowledged she had made a mistake when she crushed the metoprolol succinate ER and isosorbide mononitrate ER tablets for administration to the resident.

An interview was conducted on 3/28/19 at 4:05 PM with the facility ' s Administrator and Director

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 03/28/2019

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 759	Continued From page 22 of Nursing (DON). During the interview, the facility ' s medication errors and medication error rate were discussed. When asked, the Administrator stated she would expect the nurses to follow the facility ' s med administration policies and procedures.	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Nurse Practitioner (NP) interviews, and record review, the facility failed to utilize the correct sliding scale insulin (SSI) regimen to determine the dose of insulin administered as recommended by a resident ' s endocrinologist and ordered by the physician for 1 of 6 residents whose medications were reviewed (Resident #82). The findings included: Resident #82 was admitted to the facility on 2/29/16. Her cumulative diagnoses included diabetes, Stage 3 (moderate) chronic kidney disease, and cognitive communication deficit. Review of a Report of Consultation dated 1/24/19 from Resident #82's endocrinologist's office revealed the recommendations included continuing Novolog sliding scale insulin (SSI) utilizing the following parameters: If blood glucose level is 150-200 = administer 2 units insulin; If blood glucose level is 201-250 = administer 4	F 760	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.	4/25/19

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 03/28/2019

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 760	Continued From page 23 units insulin; If blood glucose level is 251-300 = administer 6 units insulin; If blood glucose level is 301-350 = administer 8 units insulin, If blood glucose level is 351-400 = administer 10 units insulin; If blood glucose level is 401-450 = administer 12 units insulin; Call Medical Doctor (MD) if blood glucose is greater than 451. A hand-written notation in the margin of the consultation report noted "OK," along with the name of the facility's Nurse Practitioner (NP) #1. A review of Resident #82's medication orders included a physician's verbal order dated 1/28/19 for Novolog sliding scale insulin to be administered in accordance with the endocrinologist ' s recommendations and parameters: If blood glucose level is 150-200 = administer 2 units insulin; If blood glucose level is 201-250 = administer 4 units insulin; If blood glucose level is 251-300 = administer 6 units insulin; If blood glucose level is 301-350 = administer 8 units insulin, If blood glucose level is 351-400 = administer 10 units insulin; If blood glucose level is 401-450 = administer 12 units insulin; A review of Resident #82's Medication Administration Records (MARs) from 1/28/19 through 3/24/19 revealed the parameters listed for SSI were different from those indicated by the 1/28/19 physician's order for SSI. The blood	F 760	On 3/25/19 Charge Nurse notified provider of Insulin administration dose and obtained clarification orders on Insulin Sliding Scale for Resident #82. On 3/25/19 the IDT Members reviewed all residents receiving insulin. No negative findings noted and no new orders received. On 4/18/19 the SF initiated re-education to all licensed nursing staff and medication aides, including agency staff, to include the Seven Rights of Medication Administration. By 4/25/19 all licensed nursing staff and medication aides, including newly hired licensed nursing staff and medication aides, including agency staff, will be re-educated by the SF to include the Seven Rights of Medication Administration. This education will be part of the orientation process for all newly hired licensed nursing staff, medication aides, including agency staff. Facility Pharmacist and the DON 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. All results of audits will be presented in monthly QA meeting for 3 months and as needed. Immediate action and/or re-education will be completed if any areas are identified.	

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 03/28/2019

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 760	Continued From page 24 glucose/insulin parameters on these MARs indicated: If blood glucose level is 150-200 = administer 1 unit insulin; If blood glucose level is 201-250 = administer 2 units insulin; If blood glucose level is 251-300 = administer 3 units insulin; If blood glucose level is 301-350 = administer 4 units insulin, If blood glucose level is 351-400 = administer 5 units insulin; If blood glucose level is 401-450 = administer 6 units insulin; Call Medical Doctor (MD) if blood glucose is greater than 451. Resident #82 ' s blood glucose was scheduled to be checked daily with Novolog sliding scale insulin coverage to be administered in accordance with the SSI regimen each day at 7:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM. Resident #82's January 2019 MAR indicated the dose of SSI administered to the resident differed from the 1/28/19 SSI orders on multiple occasions: --1/28/19: 2 units of Novolog SSI were injected on 2 occasions (should have been 4 units each time). --1/29/19: 3 units of Novolog SSI were injected on 1 occasion (should have been 6 units). --1/30/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 4 units of insulin were injected on 1 occasion (should have been 2 units); and 5 units of insulin were injected on 2 occasions (should have been 10 units each time). --1/31/19: 2 units of Novolog SSI were injected on 2 occasions (should have been 4 units each	F 760	The IDT Members are responsible for the Plan of Correction and the DON is responsible for sustained compliance.	

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 03/28/2019

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 760	Continued From page 25	F 760		

time); 3 units of insulin were injected on 1 occasion (should have been 6 units).

Resident #82's February 2019 MAR indicated the dose of SSI administered to the resident differed from the 1/28/19 SSI orders on multiple occasions:
--2/1/19: 2 units of Novolog SSI were injected on 1 occasion (should have been 4 units); 3 units of insulin were injected on 1 occasion (should have been 6 units); 4 units of insulin were injected on 1 occasion (should have been 8 units); 6 units of Novolog SSI were injected on 1 occasion (should have been 12 units).
--2/2/19: 1 unit of Novolog SSI was injected on 3 occasions (should have been 2 units each time).
--2/3/19: 4 units of Novolog SSI were injected on 1 occasion (should have been 8 units); 6 units of insulin were injected on 2 occasions (should have been 12 units each time).
--2/4/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 3 units of insulin were injected on 1 occasion (should have been 6 units); and 5 units of insulin were injected on 1 occasion (should have been 10 units).
--2/5/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 1 occasion (should have been 4 units).
--2/6/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); and 3 units of insulin were injected on 2 occasions (should have been 6 units each time).
--2/7/19: 3 units of Novolog SSI were injected on 1 occasion (should have been 6 units); 4 units of insulin were injected on 2 occasions (should have been 8 units each time).
--2/8/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of

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 03/28/2019

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 760	Continued From page 26	F 760		

insulin were injected on 1 occasion (should have been 4 units); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--2/9/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 1 occasion (should have been 4 units); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--2/10/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 1 occasion (should have been 4 units); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--2/11/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--2/12/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units).
--2/13/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 2 occasions (should have been 4 units each time); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--2/14/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 1 occasion (should have been 4 units); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--2/15/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 3 units of insulin were injected on 1 occasion (should have been 6 units); and 4 units of insulin were injected on 2 occasions (should have been 8 units each time).
--2/16/19: 3 units of Novolog SSI were injected on 3 occasions (should have been 6 units each time).

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 03/28/2019

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 760	Continued From page 27	F 760		

--2/17/19: 3 units of Novolog SSI were injected on 1 occasion (should have been 6 units).
--2/18/19: 2 units of Novolog SSI were injected on 1 occasion (should have been 4 units); and 4 units of insulin were injected on 1 occasion (should have been 8 units).
--2/19/19: 2 units of Novolog SSI were injected on 2 occasions (should have been 4 units each time); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--2/20/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--2/21/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 3 units of insulin were injected on 1 occasion (should have been 6 units); and 4 units of insulin were injected on 1 occasion (should have been 8 units).
--2/22/19: 3 units of Novolog SSI were injected on 2 occasions (should have been 6 units each time).
--2/23/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 3 units of insulin were injected on 1 occasion (should have been 6 units); and 5 units of insulin were injected on 1 occasion (should have been 10 units).
--2/24/19: 2 units of Novolog SSI were injected on 2 occasions (should have been 4 units each time); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--2/25/19: 3 units of Novolog SSI were injected on 1 occasion (should have been 6 units); 4 units of insulin were injected on 2 occasions (should have been 8 units each time); and 5 units of insulin were injected on 1 occasion (should have been 10 units).
--2/26/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 3 units of

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 03/28/2019

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 760	Continued From page 28	F 760		

insulin were injected on 1 occasion (should have been 6 units); and 5 units of insulin were injected on 1 occasion (should have been 10 units).
--2/27/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 3 units of insulin were injected on 2 occasions (should have been 6 units each time); and 4 units of insulin were injected on 1 occasion (should have been 8 units).
--2/28/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); and 4 units of insulin were injected on 1 occasion (should have been 8 units).

Resident #82's March 2019 MAR indicated the dose of SSI administered to the resident differed from the 1/28/19 SSI orders on multiple occasions:
--3/1/19: 2 units of Novolog SSI were injected on 1 occasion (should have been 4 units); 3 units of insulin were injected on 1 occasion (should have been 6 units); and 4 units of insulin were injected on 1 occasion (should have been 8 units).
--3/2/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--3/3/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 1 occasion (should have been 4 units); 3 units of insulin were injected on 1 occasion (should have been 6 units); and 4 units of insulin were injected on 1 occasion (should have been 8 units).
--3/4/19: 2 units of Novolog SSI were injected on 1 occasion (should have been 4 units); 5 units of insulin were injected on 1 occasion (should have been 10 units); and 6 units of insulin were injected on 1 occasion (should have been 12

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 03/28/2019

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 760	Continued From page 29	F 760		

units).
--3/5/19: 5 units of Novolog SSI were injected on 1 occasion (should have been 10 units); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--3/6/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 1 occasion (should have been 4 units); and 6 units of insulin were injected on 1 occasion (should have been 12 units).
--3/7/19: 2 units of Novolog SSI were injected on 1 occasion (should have been 4 units); 3 units of insulin were injected on 1 occasion (should have been 6 units); and 6 units of insulin were injected on 1 occasion (should have been 12 units).
--3/8/19: 4 units of Novolog SSI were injected on 1 occasion (should have been 8 units); and 5 units of insulin were injected on 1 occasion (should have been 10 units).
--3/9/19: 1 unit of Novolog SSI was injected on 2 occasions (should have been 2 units each); and 2 units of insulin were injected on 1 occasion (should have been 4 units).
--3/10/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 1 occasion (should have been 4 units); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--3/11/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 2 occasions (should have been 4 units); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--3/12/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 2 occasions (should have been 4 units each time); and 6 units of insulin were injected on 1 occasion (should have been 12 units).

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 03/28/2019

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 760	Continued From page 30	F 760		

--3/13/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 1 occasion (should have been 4 units); 3 units of insulin were injected on 1 occasion (should have been 6 units); and 5 units of insulin were injected on 1 occasion (should have been 10 units).
--3/14/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 3 occasions (should have been 4 units each time).
--3/15/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 3 units of insulin were injected on 1 occasion (should have been 6 units); and 4 units of insulin were injected on 1 occasion (should have been 8 units).
--3/16/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 3 occasions (should have been 4 units each time).
--3/17/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); 2 units of insulin were injected on 1 occasion (should have been 4 units); and 3 units of insulin were injected on 1 occasion (should have been 6 units).
--3/18/19: 1 unit of Novolog SSI was injected on 2 occasions (should have been 2 units each time); and 2 units of insulin were injected on 1 occasion (should have been 4 units).
--3/19/19: 3 units of insulin were injected on 1 occasion (should have been 6 units).
--3/20/19: 2 units of Novolog SSI were injected on 1 occasion (should have been 4 units); and 4 units of insulin were injected on 1 occasion (should have been 8 units).
--3/21/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); and 3 units of insulin were injected on 1 occasion (should have been 6 units).

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 03/28/2019

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 760	Continued From page 31	F 760		

--3/22/19: 2 units of Novolog SSI were injected on 1 occasion (should have been 4 units); 3 units of insulin were injected on 1 occasion (should have been 6 units); and 6 units of insulin were injected on 1 occasion (should have been 12 units).
--3/23/19: 1 unit of Novolog SSI was injected on 1 occasion (should have been 2 units); and 3 units of insulin were injected on 2 occasions (should have been 6 units each time).
--3/24/19: 1 unit of Novolog SSI was injected on 2 occasions (should have been 2 units each time); and 3 units of insulin were injected on 1 occasion (should have been 6 units).

On 3/25/19 at 4:25 PM, Nurse #1 was observed as she checked Resident #82 ' s blood glucose (blood sugar). The resident ' s blood glucose level was 242 milligram/deciliter (mg/dl). After the blood glucose check was completed, the nurse reviewed the sliding scale insulin regimen on the resident ' s electronic Medication Administration Record (MAR) to determine how many units of insulin needed to be injected for a blood glucose result of 242 mg/dl. Nurse #1 was then observed as she prepared and injected 2 units of Novolog insulin (a rapid acting insulin) subcutaneously (SQ) for Resident #82.

An interview was conducted on 3/25/19 at 4:45 PM with Nurse #1. Upon request, the nurse reviewed the SSI regimen on Resident #82 ' s MAR. The SSI regimen listed on the MAR was different from the 1/28/19 physician ' s order. The MAR indicated: If blood glucose 150-200 = 1 unit of insulin was to be administered; 201-250 = 2 units; 251-300 = 3 units; 301-350 = 4 units, 351-400 = 5 units; 401-450 = 6 units; Call MD if blood glucose is greater than 451.

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 03/28/2019

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 760	Continued From page 32	F 760		

Upon her request, a follow-up interview was conducted with Nurse #1 on 3/25/19 at 5:00 PM. During this interview, the nurse stated the facility had called and received an MD clarification of Resident #82 ' s order for Novolog sliding scale insulin (originally dated 1/28/19). The nurse reported that for some reason, the correct sliding scale insulin regimen had not carried over onto the resident ' s MAR when the 1/28/19 physician ' s order for SSI was put in.

An interview was conducted on 3/27/19 at 1:40 PM with Nurse #3. Nurse #3 was identified as the nurse who input Resident #82 ' s SSI physician's order into the facility ' s electronic system on 1/28/19. The nurse reviewed the computer orders in the resident's electronic chart. She explained use of the electronic MARs was new to the facility as of last August (2018). Nurse #3 reported that apparently when the new order was input into the computer, the instructions that came up on the computer did not accurately reflect the intended order for the sliding scale insulin. After the med pass observation had been conducted on 3/25/19, Nurse #3 reported the hall nurse alerted her to the concern. Nurse #3 reported the facility then contacted the resident's provider for clarification of the order. The order was clarified and instructions were given to provide Resident #82 ' s SSI as recommended by the endocrinologist and originally ordered on 1/28/19 by the provider at the facility. Upon further inquiry, the nurse confirmed this resident did not receive the SSI regimen ordered by the physician from 1/28/19 through 3/25/19 (date the order was clarified).

An interview was conducted with Nurse Practitioner (NP) #1 on 3/28/19 at 2:00 PM. NP

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 03/28/2019

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 760	Continued From page 33 #1 was assigned to help provide care for Resident #82 at the facility. During the interview, the NP recalled being contacted by the facility earlier in the week to clarify the SSI orders for Resident #82. The NP reported she instructed the facility to follow the endocrinologist's recommendations and the orders written on 1/28/19 for the resident ' s SSI. The NP stated although Resident #82 had "brittle diabetes," it would be hard to tell how the error made in the SSI regimen order would have affected this resident. She noted the resident ' s blood glucose levels were checked four times daily. Upon further inquiry, the NP stated, "Would I want them (the facility) to follow the orders correctly? Yes." An interview was conducted on 3/28/19 at 4:42 PM with the facility ' s Administrator. During the interview, the Administrator stated her expectation was for staff to transcribe the medication orders correctly and give the medication per the doctor's orders.	F 760		
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	F 761		4/25/19

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 03/28/2019

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 761	Continued From page 34 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 securely store medication in 1 of 5 medication carts observed during the medication administration observations (100 Hall Med Cart 1). The findings included: A continuous observation of a medication administration pass began on 3/25/19 at 3:30 PM with Nurse #2. Nurse #2 was assigned to the 100 Hall Med Cart 1. Upon approaching the nurse to begin the observations, a small plastic basket containing 12 vials of insulin were observed to be placed on top of the medication cart. Nurse #2 was observed as she prepared an oral medication for administration to Resident #7. At 3:35 PM, the nurse left the med cart with the vials of insulin placed on top of the cart. She went into Resident #7 ' s room and administered the resident ' s medication. The med cart was not within view of the nurse. When Nurse #2 returned to the med cart, the insulin vials were observed to remain on top of the cart.	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.	

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 03/28/2019

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 761	Continued From page 35 On 3/25/19 at 3:40 PM, Nurse #2 was observed as she prepared oral medications for administration to Resident #73. The nurse left the med cart with the vials of insulin placed on top of the cart, went into Resident #73's room, and administered the medications to the resident. The med cart was not within view of the nurse. At 3:43 PM, Nurse #2 returned to the med cart. The insulin vials were observed to remain on top of the med cart. On 3/25/19 at 3:46 PM, Nurse #2 was observed as she prepared an oral medication for administration to Resident #111. The nurse left the med cart with the vials of insulin placed on top of the cart, went into resident's room and gave the medication to the resident. At 3:48 PM, Resident #147 was observed in the hallway as she approached the 100 Hall Med Cart 1 and took two wrapped plastic spoons from the cart. At that time, Nurse #2 was in Resident #111 ' s room and the med cart was not within view of the nurse. Nurse #2 returned to the med cart at 3:50 PM. The insulin vials remained on top of the med cart. On 3/25/19 at 3:52 PM, Nurse #2 was observed as she donned gloves and gathered a glucometer, test strip, alcohol wipe, and lancet from the med cart. She then left the med cart with the vials of insulin placed on top of the cart, entered Resident #111 ' s room and completed a blood glucose check for that resident. The med cart was not within view of the nurse. When Nurse #2 returned to the med cart, the insulin vials were observed to remain on top of the cart. On 3/25/19 at 4:02 PM, Nurse #2 was observed	F 761	On 3/28/19 DON reviewed medication carts that stored medications for Resident #7, Resident #73, Resident #111, Resident #147, Resident #90 to ensure medications were secured. On 3/28/19 the IDT members observed all medication carts to ensure medications were secured. No negative findings noted. On 4/18/19 the SF initiated re-education to all licensed nursing staff and medication aides, including agency staff, to include the storage of drugs and biologicals. By 4/25/19 all licensed nursing staff and medication aides, including newly hired licensed nursing staff and medication aides, including agency staff, will be re-educated by the SF to include the storage of drugs and biologicals. This education will be part of the orientation process for all newly hired licensed nursing staff and medication aides, including agency staff. Facility Pharmacist and the DON 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. All results of audits will be presented in monthly QA meeting for 3 months and as needed. Immediate action and/or re-education will be completed if	

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 03/28/2019

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 761	Continued From page 36 to don gloves, gather supplies, and enter Resident #90 ' s room to complete a blood glucose check for the resident. The insulin vials were left on med cart and med cart was not within view of the nurse at that time. At 4:04 PM, the nurse returned to the med cart, drew up insulin for Resident #90, went into the resident's room, and administered the insulin. The med cart was not within view of the nurse while she was in the room. Nurse #2 returned to the cart at 4:08 PM after giving the insulin injection to Resident #90. An interview was conducted on 3/25/19 at 4:10 PM with Nurse #2 to discuss the medication administration observations. Upon inquiry regarding the 12 insulin vials left on the medication cart for the duration of the med pass observation, the nurse confirmed the med cart was out of her view while in the residents ' rooms. Nurse #2 stated she usually put the basket of insulin vials in the top drawer of the locked med cart, but did not do so during this med pass. An interview was conducted on 3/28/19 at 4:05 PM with the facility ' s Administrator and Director of Nursing (DON). During the interview, the Administrator stated she would expect no medications to be on top of the medication cart without a nurse or a medication aide being present.	F 761	any areas are identified. The IDT Members are responsible for the Plan of Correction and the DON is responsible for sustained compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		4/25/19

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 03/28/2019

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 880	Continued From page 37	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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 03/28/2019

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 880	Continued From page 38 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to post a contact isolation sign on the outside of a resident's door for one of five residents (Resident #125) on contact isolation precautions, failed to disinfect a shared glucometer (device used to measure a resident's blood glucose or blood sugar level) after the glucometer was used for 1 of 3 residents observed to have blood glucose monitoring (Resident #111), and failed to perform hand hygiene between residents (Residents #7 and 73; Residents #73 and #111; and Residents #111 and #90) during 1 of 5 continuous observations of a medication administration pass. Findings included:	F 880	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	

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 03/28/2019

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 880	Continued From page 39 The facility policy entitled "Guidelines for Initiation of Precautions," effective September 2014 was reviewed. The policy stated, in part, "Contact precautions in addition to standard precautions should be used for residents known or suspected with microorganisms that are easily transmitted by direct or indirect contact ...As indicated, post appropriate precautions signage on resident's room door." 1. Resident # 125 was admitted to the facility on 11/30/14. A cumulative list of diagnoses included, in part, urinary tract infection (UTI). Review of a urinalysis lab results report dated 3/23/19 at 1:35 PM and reviewed by Nurse #4 on 3/23/19 at 3:58 PM revealed a result of "greater than 100,000 colony forming units per milliliter (mL). Escherichia coli" (a bacteria). "Susceptibility profile is consistent with a probable ESBL" (extended-spectrum beta lactamase, a type of enzyme produced by bacteria). A review of a physician's order dated 3/24/19 revealed, "Invanz (an antibiotic), one gram for five days." On 3/24/19 at 11:00 AM a tour of the Spark (dementia care) unit revealed no isolation sign nor personal protective equipment (PPE) such as gowns, gloves, masks, etc., was posted on Resident #125's door. On 3/25/19 at 2:33 PM an observation of Resident #125's room revealed no isolation sign nor PPE was posted on Resident #125's door. On 3/25/19 at 2:50 PM an observation of the	F 880	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 3/28/19 the Infection Control (IC) Nurse reviewed Resident #125 and contact isolation sign was on their door. On 3/25/19 the IC Nurse disinfected the shared glucometer on the medication cart for Resident #111. On 3/28/19 the IC Nurse observed medication pass on Residents #7, #73, #111 and #90 for hand hygiene being performed between them. No negative findings were noted. On 3/28/19 the IC Nurse reviewed all residents on isolation precautions for identifying signage placed on their door. No negative findings were noted. On 3/25/19 the IC Nurse disinfected all shared glucometers on all medication carts. On 3/28/19 the IC Nurse observed all nurses on duty perform proper hand washing/sanitization and requested verbal understanding of performing it before and after each resident during medication pass administration. No negative findings were noted.	

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 03/28/2019

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 880	Continued From page 40 nurse's station for the Spark unit revealed a contact isolation sign was posted inside the nurse's station along with PPE. Resident #125's room number was written on the isolation sign. On 3/26/19 at 10:50 AM an observation of Resident #125's room revealed an isolation sign was posted on the frame of the door near the top. On 3/26/19 at 4:12 PM an interview was completed with Nurse #4. He said he was the nurse supervisor on 3/23/19 when the urinalysis results were received by the facility. He stated the process that was followed when abnormal test results were received included notification of the physician or provider. Nurse #4 said contact precautions were initiated based on facility protocol and provider orders. Nurse #4 indicated he was an agency nurse and since he didn't know the facility's protocol would have referred to the facility's protocol book. He recalled that he reviewed the lab results and contacted the provider and obtained orders for an antibiotic. Nurse #4 did not indicate whether he had initiated contact precautions but stated the nurses worked together as a team. On 3/27/19 at 8:29 AM an interview was completed with Nurse #5. She said she worked on 3/23/19 when the urinalysis test results were received for Resident #125. She reported that the test results indicated Resident #125 had ESBL in the urine. She said when ESBL was present the resident was immediately placed on contact precautions and stated contact precautions could be initiated by any nurse. She said when a resident on the Spark unit was placed on contact precautions the sign and PPE was posted inside the nurse's station instead of	F 880	On 3/28/19 the Administrator re-educated the Infection Control nurse on Isolation Precautions to include signage postage of isolation on the outside of a resident□s door. On 3/28/19 the SF re-educated to all licensed nursing staff, including agency staff, to include initiating isolation precautions upon the need for them and making sure isolation signage is on the outside of the resident□s door. By 4/25/19 all licensed nursing staff, including agency staff will be re-educated by the SF , to include initiating isolation precautions upon the need for them and making sure isolation signage is on the outside of the resident□s door. This education will be part of the orientation process for all newly hired licensed nursing staff, including agency staffing. On 3/25/19 the SF initiated re-education to all licensed nursing staff, medication aides including agency staff, to include glucometer cleaning and disinfecting with return demonstration. On 4/1/19 the SF completed the re-education with return demonstration to all licensed nursing staff and medication aides, including agency staff. On 4/18/19 the SF initiated re-education to all licensed nursing staff, medication aides including agency staff, to include hand washing/sanitization before and after each resident during medication	

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 03/28/2019

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 880	Continued From page 41 the resident's door since some of the residents on the Spark unit removed the isolation signs or PPE from the room doors. Nurse #5 stated she couldn't remember if Resident #125 was placed on contact precautions on 3/23/19. On 3/25/19 at 2:50 PM an interview was completed with Nurse #7. She said Resident #125 was on contact precautions for ecoli in the urine. She stated a contact isolation sign and PPE were posted inside the nurse's station instead of on the resident's door which prevented other residents on the Spark unit from removing the items from Resident #125's door. On 3/25/19 at 2:52 PM an interview was completed with nurse aide (NA) #2. She said Resident #125 was on contact precautions for ecoli. She stated typically the nurse informed the nurse aides when a resident was placed on contact precautions and the isolation sign and PPE were located inside the nurse's station. On 3/26/19 at 11:35 AM an interview was completed with the Infection Control Nurse. She stated Resident #125's urinalysis results were received by the facility on 3/23/19 and indicated "ecoli with probable ESBL." She said the resident was placed on contact precautions on 3/24/19 after the Infection Control Nurse reviewed the results. She further stated contact precautions could be initiated by any nurse and the nurse on duty 3/23/19 should have initiated contact precautions upon receipt of the test results. On 3/25/19 at 2:43 PM an interview was completed with the Director of Nursing (DON). She said the facility had not placed contact precaution signs or PPE on residents' doors on	F 880	administration pass. By 4/25/19 all licensed staff and medication aides, including newly hired licensed staff and medication aides, including agency staff, will be re-educated by the SF to include hand washing/sanitization before and after each resident during medication administration pass. This education will be part of the orientation process for all newly hired licensed staff and medication aides, including agency staff. The QI and/or the DON will perform random IC signage audits to ensure signage is appropriately posted and random medication pass audits to ensure blood glucose checks and appropriate disinfection of meters is monitored 3 times a week for 4 weeks, then weekly for 8 weeks and as needed. The Compliance Monitoring Tool will be utilized. All results of audits will be presented in monthly QA meeting for 3 months and as needed. Immediate action and/or re-education will be completed if any areas are identified. The IDT Members are responsible for the Plan of Correction and the DON is responsible for sustained compliance.	

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 03/28/2019

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 880	Continued From page 42	F 880		

the Spark unit because the residents removed the signs and/or PPE and it was a safety hazard. She stated facility posted contact precaution signs and PPE inside the nurse's station and nurses communicated to staff when a resident was on contact isolation precautions.

On 3/28/19 at 10:51 AM an interview was completed with the Administrator. She said a contact precautions sign was not posted on Resident #125's door due to a history of other residents on the Spark unit who removed the sign and PPE and considered it a safety issue. She stated that going forward she expected the contact precautions sign be posted on the resident's door.

2. A review of the facility ' s policy on Glucometer - Cleaning and Disinfection (revised 9/4/14) was conducted. The procedures included, in part:

"3) If no visible blood or body fluids are present:

a) Use EPA-registered germicidal disposable cloth/wipe to thoroughly wet the entire external surface of the glucometer,

b) Then cover/wrap the entire glucometer with the wipe, and

c) Place in a plastic disposable cup on the med cart and allow full minutes ' exposure time according to the manufacturer ' s product directions for disinfection of the glucometer.

4) After full minutes ' exposure time according to manufacturer ' s product directions, remove cloth wipe and discard. Return glucometer to plastic cup to allow it to

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 03/28/2019

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 880	Continued From page 43	F 880		

thoroughly air dry.

5) Remove and discard gloves. Wash and/or sanitize hands with waterless hand hygiene gel.

6) When glucometer is completely dry, it may be used for next resident or if not proceeding to another resident, store glucometer in med cart or specified storage area. Discard disposable plastic cup after each use."

On 3/25/19 at 3:52 PM, Nurse #2 was observed as she donned gloves and gathered a glucometer, test strip, alcohol wipe, and lancet from the med cart. She then entered Resident #111 ' s room and completed a blood glucose check for the resident. After the blood glucose check, the nurse removed her gloves and returned to the med cart. She placed the glucometer on top of the med cart. The glucometer was not disinfected. A continuous observation was made as this glucometer remained on top of the med cart.

The med administration observation continued as Nurse #2 was observed gathering supplies to do a blood glucose check for Resident # 90. On 3/25/19 at 3:56 PM, the nurse donned gloves, then picked up the glucometer placed on top of the med cart (previously used for Resident # 111). The nurse began to walk into Resident #90's room. Upon request, the nurse returned to the med cart. At that time, the nurse was asked when she would need to disinfect this shared glucometer. The nurse responded by saying, "A lot of times after the first round (of blood glucose checks). We can wipe it down sometimes between residents." The nurse was then asked to disinfect the glucometer before proceeding to use the shared glucometer for Resident #90. Manufacturer instructions on the germicidal wipes

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 03/28/2019

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 880	Continued From page 44	F 880		

stored on the medication cart were reviewed and Nurse #2 was observed as she disinfected the shared glucometer before proceeding to use the glucometer for the next resident (Resident #90).

A follow up interview was conducted with Nurse #2 on 3/25/19 at 5:08 PM. When asked, the nurse reiterated that she typically disinfected the shared glucometer on her med cart after "one round" of blood glucose checks was completed. Upon further inquiry, the nurse estimated the "round" of blood glucose checks on her usual hall assignment included approximately 12-13 residents.

An interview was conducted on 3/25/19 at 5:20 PM with the facility ' s Administrator. During the interview, concerns regarding the failure to initiate disinfection of a shared glucometer during a med administration observation were discussed.

An interview was conducted on 3/28/19 at 4:05 PM with the facility ' s Administrator and Director of Nursing (DON). During the interview, failure to disinfect a shared glucometer between residents was again discussed. The Administrator stated she would expect the policy (on glucometer cleaning and disinfection) to be followed. When asked if a shared glucometer needed to be disinfected between residents, the Administrator responded by saying, "Yes." She stated a shared glucometer needed to be disinfected before and after each use.

3. On 3/25/19 at 3:30 PM, Nurse #2 was observed as she prepared an oral medication for administration to Resident #7. At 3:35 PM, the nurse administered the resident ' s medication mixed with applesauce via spoon, brought a cup

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 03/28/2019

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 880	Continued From page 45	F 880		

of water to resident's mouth and tipped it for her to drink. The nurse was observed to pat Resident #7 on the shoulder with her hand after the medication administration. Upon returning to the med cart, Nurse #2 did not wash her hands or use hand sanitizer. A continuous observation was made as the nurse failed to wash her hands or use hand sanitizer before moving on to the next resident during the medication administration pass.

On 3/25/19 at 3:40 PM, Nurse #2 was observed as she prepared oral medications for administration to Resident #73. The nurse went into resident's room, raised the resident's bed, brought the med cup up to the resident's mouth, and assisted her to drink water from the cup after taking her medication. Upon returning to the med cart, the nurse did not wash her hands or use hand sanitizer. A continuous observation was made as the nurse failed to wash her hands or use hand sanitizer before moving on to the next resident during the medication administration pass.

On 3/25/19 at 3:46 PM, Nurse #2 was observed as she prepared an oral medication for administration to Resident #111. The nurse went into resident's room and gave the medication to the resident. Upon returning to the med cart, the nurse did not wash her hands or use hand sanitizer. A continuous observation was made as the nurse failed to wash her hands or use hand sanitizer before moving on to the next resident during the medication administration pass.

On 3/25/19 at 3:52 PM, Nurse #2 was observed as she donned gloves and gathered a glucometer, test strip, alcohol wipe, and lancet

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 03/28/2019

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 880	Continued From page 46	F 880		

from the med cart. She then entered Resident #111 ' s room and completed a blood glucose check for the resident. After the blood glucose check, the nurse removed her gloves and returned to the med cart. Upon returning to the med cart, the nurse did not wash her hands or use hand sanitizer. A continuous observation was made as the nurse failed to wash her hands or use hand sanitizer before moving on to the next resident during the medication administration pass.

On 3/25/19 at 4:02 PM, Nurse #2 was observed to don gloves and gather supplies to do a blood glucose check for Resident #90. The nurse removed her gloves and returned to the med cart. Nurse #2 then drew up insulin for Resident #90, donned gloves, picked up an alcohol wipe, went into the resident's room and administered the insulin. Nurse #2 returned to the cart at 4:08 PM after giving the insulin injection to Resident #90. Upon returning to the med cart, the nurse did not wash her hands or use hand sanitizer. The continuous observation revealed Nurse #2 failed to wash her hands or use hand sanitizer at any point in time during the med administration observations.

An interview was conducted on 3/25/19 at 4:10 PM with Nurse #2 to discuss the medication administration observations. At that time, the nurse was asked when she would typically wash her hands or use a hand sanitizer during med administration. The nurse stated she would usually use hand sanitizer between residents. However, Nurse #2 acknowledged she had not done so during the med pass observation. At that time, the nurse was observed as she looked through the med cart drawers. Nurse #2 reported

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 03/28/2019

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 880	Continued From page 47 no hand sanitizer was stored on the med cart. She stated she would obtain some hand sanitizer and put it on the cart. An interview was conducted on 3/28/19 at 4:05 PM with the facility ' s Administrator and Director of Nursing (DON). During the interview, the Administrator stated she would expect the nurses and medication aides to follow the federal guidelines in regards to handwashing. When asked if she would expect the nurse to wash or sanitize his/her hands between residents during medication pass, the Administrator stated, "Yes."	F 880		