PRINTED: 03/28/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--------------|-----|---|------------------------|--------------------|
| | | 345050 | B. WING _ | | | C 02/23/2017 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | 1 | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 02/ | 23/2017 |
| | | | | 1 | 721 BALD HILL LOOP | | |
| JACOB'S | CREEK NURSING AND F | REHABILITATION CENTER | | | MADISON, NC 27025 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) COMPLETION |
| PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | DATE |
| F 248 | 483.24(c)(1) ACTIVIT | TES MEET | F: | 248 | | | 3/19/17 |
| SS=E | | | | | | | |
| | (c) Activities. | | | | | | |
| | (1) The facility must p | | | | | | |
| | | ssment and care plan and ch resident, an ongoing | | | | | |
| | | esidents in their choice of | | | | | |
| | | -sponsored group and | | | | | |
| | | nd independent activities, | | | | | |
| | | interests of and support the | | | | | |
| | ' ' | psychosocial well-being of | | | | | |
| | | raging both independence | | | | | |
| | | community. is not met as evidenced | | | | | |
| | by: Based on observation | ns, staff interviews and | | | Jacob's Creek Nursing and Rehabilitat | ion | |
| | record reviews, the fa | | | | Center acknowledges receipt of the | .011 | |
| | on-going activities for | | | | Statement of Deficiencies and propose | s | |
| | | s (Residents #52, #59, #100, | | | this Plan of Correction to the extent tha | | |
| | #129, #142, #145, #1 | 74, #192 and #107. | | | the summary of findings is factually | | |
| | The findings included | : | | | correct and in order to maintain | | |
| | | | | | compliance with applicable rules and | | |
| | | admitted on 9/15/13. The | | | provisions of quality of care of residents | | |
| | • | ognition communication | | | The Plan of Correction is submitted as | а | |
| | | . The Minimum Data Set | | | written allegation of compliance. | | |
| | | 6 coded Resident #52 ith participation in activities. | | | Jacob⊟s Creek Nursing and | | |
| | | assessment form dated | | | Rehabilitation Center s response to th | is | |
| | | sident #52 interest included | | | Statement of Deficiencies does not | | |
| | | ainting, sports, religious | | | denote agreement with the Statement | of | |
| | | s and worship services) | | | Deficiencies nor does it constitute an | | |
| | television, socials mu | | | | admission that any deficiency is accura | ite. | |
| | newspapers. | | | | Further, Jacob⊡s Creek Nursing and | | |
| | Review of the activity | | | | Rehabilitation Center reserves the right | t to | |
| | documented the resid | | | | refute any of the deficiencies on this | | |
| | | owever would join group | | | Statement of Deficiencies through | | |
| | activities of choice/int | | | | Informal Dispute Resolution, formal | | |
| | encourage out of roor | m group events, | <u> </u> | | appeal procedure, and/or any other | | |
| ABOBATORY | DIDECTOR'S OR PROVIDERS | SUPPLIER REPRESENTATIVE'S SIGNATURE | | | TITI E | | (X6) DATE |

03/16/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING _ | | | C 02/23/2017 | |
| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 1721 BALD HILL LOOP MADISON, NC 27025 | DDE | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIA | | |
| F 248 | problems. Review of the care in the problem as a character of the care in the problem as a character of the goal included requestions statement verbalization. The intencourage small gradistening to music, sevents). An observation of the secured unit on 2/22 activities were sched 11:00 AM, bible study and 3:30 PM noodleme. The activities cathe facility included AM, bible study, 3:00 church. During an observation of the 10:30 AM activity limber up activity did activity staff on the compact of the scheduled activity the scheduled activity the hall was bible states. | es, 1:1 programs as itoring for needs and/or colan dated 1/12/17, identified ronic decline in intellectual erized by deficit in memory, d thought process related to orgnitive communication deficit. esident would respond to | F 2 | administrative or legal proces F248 On 2/24/2017, the activity of performed a group activity of including Residents #52, #5 #142, #145, #174, #192 and according to the resident sand choice. On 2/24/2017, the activity of completed an audit of the later activities in the dementia (Structure of the audit was completed us activity log. No other issues activities were identified by director on 2/24/2017. On 3/15/2017, the director of (DON) in-serviced the activity activity assistant regarding activities according to reside providing alternate activities activity is cancelled, communursing staff when an activities activity staff. The administrator and/or Doministrator and/or | irector with resident 59, #100, #1 d #107 c care plan, director ast 30 days of spark() unit ad been held sing the faci so with misse the activity of nursing ity director a providing ent choice, so when an unicating wit ty cancels, sities during The training of all new ON will be I activities, a the calenda review will e activity d throughout ector will ass | of to d. ility ed and will and ar be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING | | | l | 23/2017 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 02/ | 23/2017 | |
| | | | | 17 | 721 BALD HILL LOOP | | | |
| JACOB'S | CREEK NURSING AND I | REHABILITATION CENTER | | М | IADISON, NC 27025 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 248 | Continued From page | e 2 | F | 248 | | | | |
| | and there was no alte designated activity st unit. | ernate activity provided. The aff was not present on the | | | (SPARK) unit to provide, guide, and ensure activities are completed accord to the schedule. The activity director o assistant(s) will call the facility, or verball | r | | |
| | During an observation on 2/22/17 at 2:30 PM, the scheduled activity for the secured unit was current events and this activity did not occur. The activity staff was not present on the unit and there was no alternate activity offered. | | | | notify nursing staff at least 30 minutes before any scheduled activity when the activity has been cancelled or is differe | | | |
| | | | | | than the printed calendar. The activity director or activity assistant will provide alternate activity if an activity group | an | | |
| | During an observation on 2/22/17 at 3:00 PM noodle ball was scheduled on the secured unit. This activity did not occur. Resident #52 remained in the day room and there was no | | | | cancels or does not arrive. The administrator, DON, quality assurance nurse, or assistant director of | of | | |
| | | ided. The designated activity | | | nursing will use the SPARK Unit audit to observe 5 activities per week x 12 weeks in the dementia (SPARK) unit. | ool | | |
| | During an observation on 2/22/17 at 4:00 PM, the scheduled activity for the secured unit was sing with me. This activity did not occur. A continuous observation was done 4:00 PM to 5:00 PM and Resident #52 remained in the day room until the dinner meal was set up, there was no alternate activity provided. | | | | results of the audits will be presented be the DON at the monthly Quality Assura meeting for 3 months for further review and recommendations. | nce | | |
| | scheduled activity on services. This activity residents were not in cancelled. Residents asked by surveyor. T | did not occur and the formed the activity was that were asked up were he residents that were up re informed the activity was | | | | | | |
| | Assistant Director of the activities assistant | n 2/22/17 at 5:42 PM, the Nursing (ADON) stated that t #1was responsible for r residents on the secured ated the designated | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING _ | | | C 2/23/2017 | |
| | ROVIDER OR SUPPLIER | ND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 1721 BALD HILL LOOP MADISON, NC 27025 | • | 212012011 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 248 | activity schedule. During interview of Activity Assistant (responsible for the AA#1 confirmed the scheduled for 2/22 accordance to the alternates provide system in place to was sick or when abe done. AA#1 fur program was scheduled activities staff was know and do an all During an interview Administrator and stated the expectate to provide the scheduled and administrator and assigned to the seprovided the activities delendar. If the vocancelled the residuled and the confirmed there we place to monitor to being provided with stated it was here activities be impleit scheduled activity notified of the charman and the charman are reactivities and the charman are reactivities be impleit scheduled activity notified of the charman are reactivities of the charman are reactivities. | ave occurred in accordance to in 2/23/17 at 10:49 AM, the (AA #1), stated she was a activities on the secured unit. The activities that were (2/17) were not done in calendar and there were no in calendar and there was no provide coverage when she as scheduled events could not there stated when an outside aduled and it was cancelled the expected to let the residents atternate activity. What on 2/23/17 at 11:00AM, the Director of Nursing (DON), atton was for the activities staff eduled activities in accordance d/or provide alternate activities activities were cancelled. The DON indicated that AA#1 was accured unit and should have attest as scheduled on the daily lunteers or outside resources dent needed to be notified. The control of the scheduled 7:00PM as no designated system in the polymer of the polyme | F 2 | 48 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING _ | | | C 02/23/2017 | |
| | PROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COD 1721 BALD HILL LOOP MADISON, NC 27025 | | 212312011 | |
| (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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 248 | Activity Assistant (AA responsible for the a activities. The AA #2 were responsible for ready for activities. A occurred on the assist the schedule and the rooms as assigned. scheduled activities If the activity did not on indicated when the othey usually called arresident's know. She unaware of the back when the assigned a present on the unit. identified by either A. 2. Resident #59 was diagnoses included A cognition communicated by a cooking/baking, televants/crafts, gardening study, devotions and cooking/baking, televants/crafts, gardening | A) #2 indicated that she was ctivities on the halls and 1:1 stated the nursing assistants getting residents up and vA#2 reported activities had gned hall in accordance to e1:1 were done in resident. When asked about specific like bible study she confirmed ocur for the day. The AA#2 lutside programs cancelled and then staff would let the further stated she was up plan for the 500/600 hall ctivities person was not. The back-up plan was not A #1 or AA #2. I admitted on 6/10/08. The Alzheimer 's dementia and lation deficit. The Minimum and 12/8/16 coded Resident lice with participation in assessment form dated lesident #59 interest included go, bingo, trivia, religious (bible worship services), vision, socials, puzzles, ry, bluegrass and rock n roll), pers. I note dated 12/2/16, dent needed reminder of and that he actively ured out of room group | F 2 | 48 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION NG | (X3 | (X3) DATE SURVEY COMPLETED | |
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| 345050 | | | B. WING _ | | | C 02/23/2017 |
| | ROVIDER OR SUPPLIER | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATI 1721 BALD HILL LOOP MADISON, NC 27025 | E, ZIP CODE | 02/23/2017 |
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| F 248 | Continued From page | e 5 | F 2 | 248 | | |
| | functioning character decision making and Alzheimer's and coo The goal included res questions statement verbalization. The int encourage small grou | | | | | |
| | secured unit on 2/22/ activities were sched 11:00 AM, bible study and 3:30 PM noodle me. The activities cal the facility included 1 | e activities calendar on the day of the following uled: 10:30 AM, limber up, y, 2:30 PM current events ball and 4:00 PM sing with lendar in other sections of 0:30 AM, limber up 11:00 PM, bingo and 7:00PM | | | | |
| | 2/22/17 at 10:30 AM, seated in the day roo the 10:30 AM activity limber up activity did | n on the secured unit on the following resident was m: Resident #59, waiting for to occur. The scheduled not occur. There was no nit and the nursing assistants o the other residents. | | | | |
| | the scheduled activity the hall was bible stu occur. Resident #59 and there was no alto | n on 2/22/17 at 11:00 AM, y for the secured unit and on dy. This activity did not remained in the day room ernate activity provided. The aff was not present on the | | | | |
| | During an observatio | n on 2/22/17 at 2:30 PM, the | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025 | 1 0 | 212312011 | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 248 | current events and the activity staff was not was no alternate act. During an observation noodle ball was scheen this activity did not ore remained in the day alternate activity prostaff was not present. During an observation scheduled activity for with me. This activity observation was don Resident #59 remained inner meal was set activity provided. During an observation scheduled activity or services. This activity residents were not in cancelled. Residents asked by surveyor. It was asked if they we cancelled and many. During an interview of Assistant Director of the activities assistant providing activities for unit. The ADON indicactivities should have activity schedule. | r the secured unit was his activity did not occur. The present on the unit and there ivity offered. In on 2/22/17 at 3:00 PM eduled on the secured unit. Occur. Resident #59 room and there was no vided. The designated activity it on the unit. In on 2/22/17 at 4:00 PM, the r the secured unit was sing of did not occur. A continuous he 4:00 PM to 5:00 PM and hed in the day room until the up, there was no alternate In on 2/22/17 at 7:00 PM, the note hall was church by did not occur and the hall was church by did not occur and the hall was church by did not occur and the hall was church by did not occur and the hall was responded no. In 2/22/17 at 5:42 PM, the Nursing (ADON) stated that hall that #1was responsible for or residents on the secured | F 24 | 8 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED C 02/23/2017 | |
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| | | 345050 | B. WING | | | | |
| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025 | | 212312011 | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 248 | AA#1 confirmed the scheduled for 2/22/1 accordance to the calternates provided. system in place to p was sick or when a see done. AA#1 furth program was scheduled activities staff was eknow and do an alter activities staff was eknow and do an alter activities staff was eknow and do an alter activities be implementated activities activities activities activities. The AA #2 were responsible for the activities. The AA #2 were responsible for the activities. | activities on the secured unit. activities that were 7 were not done in alendar and there were no In addition, there was no rovide coverage when she scheduled events could not er stated when an outside uled and it was cancelled the expected to let the residents rnate activity. On 2/23/17 at 11:00AM, the irector of Nursing (DON), on was for the activities staff uled activities in accordance or provide alternate activities ivities were cancelled. The DN indicated that AA#1 was used unit and should have as as scheduled on the daily inteers or outside resources int needed to be notified. The scheduled 7:00PM and happen on 2/22/17. DON and designated system in the building. The DON pectation that alternate ented when there was a hange and the resident be | F 24 | 48 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | PLE CONSTRUCTION IG | | COMPLETED | |
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| | | 345050 | B. WING_ | | | C |
| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025 | I | 02/23/2017 |
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| F 248 | the schedule and the rooms as assigned. scheduled activities the activity did not of indicated when the condition they usually called a resident's know. She unaware of the back when the assigned a present on the unit. identified by either A 3. Resident #100 wadiagnoses included and cognition comm Minimum Data Set ((Resident #100 need participation in activit Review of the activit Resident #100 's intreligious activities, led ancing and reading Review of the care participation in activit Resident #100 's intreligious activities, led ancing and reading Review of the care participation making and Alzheimer 's and confunctioning characted decision making and Alzheimer 's and confunctions statement verbalization. The in encourage small groupet therapy, listening events). Another proplan was feelings of characterized by ine bad about herself. T | gned hall in accordance to a 1:1 were done in resident. When asked about specific like bible study she confirmed cour for the day. The AA#2 butside programs cancelled and then staff would let the a further stated she was rup plan for the 500/600 hall activities person was not. The back-up plan was not A #1 or AA #2. Its admitted on 9/26/14. The wascular dementia, anxiety unication deficit. The MDS) dated 2/14/17 coded ed assistance with ties. It is a sy assessment dated 7/21/16, werest included games, eisure, arts/craft, music, included lated 12/14/16, identified fronic decline in intellectual rized by deficit in memory, a thought process related to gnitive communication deficit. Sident would respond to with appropriate | F 2 | 48 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025 | | 7212312017 | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 248 | intervention included attend group activities after reside and provide 1:1 sess reorientation. Review of the activity documented the residirected, self-directed of choice and out of would encourage out provided 1:1 program problems. An observation of the secured unit on 2/22 activities were sched 11:00 AM, bible studies and 3:30 PM noodle me. The activities cathe facility included 1 AM, bible study, 3:00 church. During an observation 2/22/17 at 10:30 AM seated in the day roof or the 10:30 AM actilimber up activity did activity staff on the unwere providing care in the scheduled activity the hall was bible study. Resident #100 ccur. Resident #100 activities to ccur. Resident #100 activities activities the provident activities the hall was bible study. | sion, anxiety or sadness. The encourage resident to s, offer assistance with not attempt activity on her own ions with resident for and independent activities room group events. Staff to froom group events, as as needed and monitor for activities calendar on the secured the following fulled: 10:30 AM, limber up, y, 2:30 PM current events ball and 4:00 PM sing with lendar in other sections of 0:30 AM, limber up 11:00 PM, bingo and 7:00PM In on the secured unit on the following resident was activity to occur. The scheduled not occur. There was no not and the nursing assistants to the other residents. In on 2/22/17 at 11:00 AM, y for the secured unit and on idy. This activity did not oremained in the day room ternate activity provided. The | F 2- | 48 | | | |

| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | 345050 | B. WING | | | C)2/23/2017 | |
| | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025 | | 7212312011 | |
| ACH DEFICIENC | CY MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION | SHOULD BE | (X5) COMPLETION DATE | |
| n observation ded activity for events and the taff was not exited all was scheet with did not consider a ctivity did not consider a ctivity provents activity provents activity from the did activity from the activity on the activity of the a | taff was not present on the an on 2/22/17 at 2:30 PM, the or the secured unit was his activity did not occur. The present on the unit and there vity offered. In on 2/22/17 at 3:00 PM aduled on the secured unit. Occur. Resident #100 aroom and there was no vided. The designated activity at on the unit. In on 2/22/17 at 4:00 PM, the or the secured unit was sing adid not occur. A continuous are 4:00 PM to 5:00 PM and and the day room until the up, there was no alternate In on 2/22/17 at 7:00 PM, the or the hall was church and the day room until the up, there was no alternate In on 2/22/17 at 7:00 PM, the or the hall was church are the hall was church are the residents that were up are informed the activity was responded no. In 2/22/17 at 5:42 PM, the Nursing (ADON) stated that an the formal was responsible for | F 24 | 48 | | | |
| | summary stach deficience activity so activity provided activity for activity did not or activity provided activity provided activity provided activity for activity for activity for activity for activity for activity for activity activity activity activity on the activity on activity on activity on activity on activity on activity on the activity on activity on the activity on the activity on activity activity on the activity on th | ASUPPLIER SUMMARY STATEMENT OF DEFICIENCIES FACH DEFICIENCY MUST BE PRECEDED BY FULL EQUILATORY OR LSC IDENTIFYING INFORMATION) Bed From page 10 ted activity staff was not present on the eactivity for the secured unit was events and this activity did not occur. The staff was not present on the unit and there eatternate activity offered. In observation on 2/22/17 at 3:00 PM and was scheduled on the secured unit. In the day room and there was not activity provided. The designated activity is not present on the unit. In observation on 2/22/17 at 4:00 PM, the ead activity for the secured unit was sing. This activity did not occur. A continuous tion was done 4:00 PM to 5:00 PM and the teal was set up, there was no alternate. | A. BUILDIN 345050 B. WING | A BUILDING 345050 B. WING STREET ADDRESS, CITY, STATE, 2IP CODE WADDSON, NC 27025 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GOULATORY OR LSC IDENTIFYING INFORMATION) BY PROVIDERS PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) BY PROVIDERS PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) BY PROVIDERS PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) BY PROVIDERS PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) BY 248 F 248 | A BUILDING 345050 8. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY TAG PROVIDENS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OF O'T HE APPROPRATE DEFICIENCY) F 248 The activity staff was not present on the In observation on 2/22/17 at 2:30 PM, the ad activity for the secured unit. was sing This activity offend. In observation on 2/22/17 at 4:00 PM, the ad activity for the secured unit was sing This activity off not occur. A continuous tion was done 4:00 PM to 5:00 PM and ## 100 remained in the day room until the ad activity on the hall was church In observation on 2/22/17 at 7:00 PM, the ad activity on the hall was church This activity off not occur and the swere not informed the activity was d. Residents that were up add if they were informed the activity was d and many responded no. In interview on 2/22/17 at 5:42 PM, the it Director of Nursing (ADON) stated that titles assistant #1 was responsible for y activities for residents on the secured ADON indicated the designated | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
|--|--|---|-------------------------|---|--|----------------------|
| | | 345050 | B. WING _ | | | C 2/23/2017 |
| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | • | STREET ADDRESS, CITY, STATE, ZIP CODE 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 | ((EACH CORRECTIVE ACTION S | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | |
| F 248 | Activity Assistant (AA responsible for the are AA#1 confirmed the ascheduled for 2/22/1 accordance to the callernates provided. It system in place to provide a system in place to provide activities staff was exponsible to the called activities staff was exponsible to the calendar and/or when scheduled activities activ | 2/23/17 at 10:49 AM, the a #1), stated she was ctivities on the secured unit. activities that were 7 were not done in addition, there was no ovide coverage when she cheduled events could not er stated when an outside alled and it was cancelled the expected to let the residents mate activity. 2/23/17 at 11:00AM, the rector of Nursing (DON), in was for the activities staffuled activities in accordance or provide alternate activities wities were cancelled. The DN indicated that AA#1 was red unit and should have is as scheduled on the daily steers or outside resources in needed to be notified. The scheduled 7:00PM into thappen on 2/22/17. DON no designated system in insure the activities were in the building. The DON ectation that alternate ented when there was a ange and the resident be | F 2 | 248 | | |
| | | (a) #2 indicated that she was | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | \ \ \ \ \ \ \ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED C 02/23/2017 | |
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| | | 345050 | B. WING | | | | |
| | NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP COL 1721 BALD HILL LOOP MADISON, NC 27025 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 248 | activities. The AA #2 were responsible for ready for activities. A occurred on the ass the schedule and the rooms as assigned. scheduled activities the activity did not o indicated when the othey usually called a resident's know. She unaware of the back when the assigned a | extivities on the halls and 1:1 2 stated the nursing assistants 3 getting residents up and AA#2 reported activities had 3 igned hall in accordance to 3 a 1:1 were done in resident 4 When asked about specific 6 like bible study she confirmed 6 ccur for the day. The AA#2 6 putside programs cancelled 6 and then staff would let the 6 a further stated she was 6 applan for the 500/600 hall 6 activities person was not 6 The back-up plan was not | F 2- | 48 | | | |
| | diagnoses included communication defice Minimum Data Set (Resident #129 needs participation in active Review of the activite 3/31/16, revealed Rearts/crafts, flowers, redevotions and worst socials, puzzles, musuals, puzzles, puz | cit and major depression. The MDS) dated 2/14/17, coded ed assistance with ities. y assessment form dated esident #129 interest included religious (bible study, nip services), television, sic and reading. I colan dated 1/6/17, identified ronic decline in intellectual rized by deficit in memory, if thought process related to gnitive communication deficit. Esident would respond to with appropriate | | | | | |

| AND DI AN OF CORRECTION IDENTIFICATION NUMBER | (X2) MULTIPI A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| 345050 | B. WING | | C 02/23/2017 | |
| NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025 | 1 02/23/2017 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | |
| listening to music, spiritual events and outdoor events). Review of the activity note dated 1/3/17, documented the resident enjoys being around others. Resident #129 was confused and had difficulty remaining focused on events/task. Staff would encourage out of room group events, provide 1:1 program as needed and actively participate in structured out of room group events of her choice. An observation of the activities calendar on the secured unit on 2/22/17 revealed the following activities were scheduled: 10:30 AM, limber up, 11:00 AM, bible study, 2:30 PM current events and 3:30 PM noodle ball and 4:00 PM sing with me. The activities calendar in other sections of the facility included 10:30 AM, limber up 11:00 AM, bible study, 3:00 PM, bingo and 7:00PM church. During an observation on the secured unit on 2/22/17 at 10:30 AM, the following resident was seated in the day room: Resident #129, waiting for the 10:30 AM activity to occur. The scheduled limber up activity did not occur. There was no activity staff on the unit and the nursing assistants were providing care to the other residents. During an observation on 2/22/17 at 11:00 AM, the scheduled activity for the secured unit and on the hall was bible study. This activity did not occur. Resident #129 remained in the day room and there was no alternate activity provided. The | F 24 | 8 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | ULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING _ | B. WING | | C 02/23/2017 | | |
| | ROVIDER OR SUPPLIER CREEK NURSING AND I | REHABILITATION CENTER | | 172 | REET ADDRESS, CITY, STATE, ZIP CODE 21 BALD HILL LOOP ADISON, NC 27025 | 1 02 | 20,2011 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE | |
| F 248 | scheduled activity for current events and the activity staff was not was no alternate activity and the activity staff was not was no alternate activity. During an observation remained in the day realternate activity provided activity for with me. This activity observation was done Resident #129 remained in the day real the activity provided. During an observation was done Resident #129 remained in the activity observation was done Resident #129 remained in the activity provided. During an observation scheduled activity on services. This activity residents were not in cancelled. Residents asked by surveyor. The was asked if they we cancelled and many the activities assistant Director of the activities assistant. | n on 2/22/17 at 2:30 PM, the the secured unit was is activity did not occur. The present on the unit and there vity offered. n on 2/22/17 at 3:00 PM duled on the secured unit. ccur. Resident #129 from and there was no rided. The designated activity on the unit. n on 2/22/17 at 4:00 PM, the the secured unit was sing did not occur. A continuous at 4:00 PM to 5:00 PM and fined in the day room until the tup, there was no alternate n on 2/22/17 at 7:00 PM, the the hall was church add not occur and the formed the activity was that were asked up were the residents that were up the informed the activity was responded no. In 2/22/17 at 5:42 PM, the Nursing (ADON) stated that the formed that the for | F | 248 | | | | |
| | unit. The ADON indic activities should have activity schedule. | r residents on the secured ated the designated coccurred in accordance to 2/23/17 at 10:49 AM, the | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING_ | | | | C 23/2017 |
| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | 1721 | EET ADDRESS, CITY, STATE, ZIP CODE I BALD HILL LOOP DISON, NC 27025 | 1 02/ | 23/2017 |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 248 | Activity Assistant (AA responsible for the and AA#1 confirmed the scheduled for 2/22/1 accordance to the callernates provided. System in place to prowas sick or when a seed to the dead activities staff was exponsible for the calendar and/of when scheduled activities activities. The AA#2 responsible for the activities. The AA#2 | at #1), stated she was ctivities on the secured unit. activities that were 7 were not done in lendar and there were no In addition, there was no ovide coverage when she cheduled events could not er stated when an outside led and it was cancelled the spected to let the residents mate activity. In 2/23/17 at 11:00AM, the rector of Nursing (DON), in was for the activities staffuled activities in accordance for provide alternate activities were cancelled. The DN indicated that AA#1 was red unit and should have is as scheduled on the daily steers or outside resources in needed to be notified. The scheduled 7:00PM mot happen on 2/22/17. DON no designated system in insure the activities were in the building. The DON ectation that alternate ented when there was a lange and the resident be | F2 | 248 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | IULTIPLE CONSTRUCTION ILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | 1721 | ET ADDRESS, CITY, STATE, ZIP CODE BALD HILL LOOP BISON, NC 27025 | | 120/2011 | |
| (X4) ID PREFIX TAG | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY) | D BE | (X5) COMPLETION DATE | |
| F 248 | occurred on the assigned the scheduled and the rooms as assigned. Scheduled activities I the activity did not on indicated when the open they usually called arresident's know. She unaware of the backwhen the assigned a present on the unit. Identified by either Availagnoses included a cognitive communication Data Set (MDS) date #142 needed assistativities. Review of the activity 7/25/16, revealed Rearts/crafts, sports, gareligious (bible study services), television. Review of the activity documented the residuation of room group evices out of room group evices and indections with verbal would encourage out provide 1:1 program participate in structur of her choice. | A#2 reported activities had gned hall in accordance to 1:1were done in resident When asked about specific like bible study she confirmed four for the day. The AA#2 sutside programs cancelled and then staff would let the further stated she was sup plan for the 500/600 hall ctivities person was not The back-up plan was not The back-up plan was not A #1 or AA #2 and addition deficit. The Minimum d 2/14/17, coded Resident ince with participation in assessment form dated sident #142 interest included limes(bingo/card games), devotions and worship and opendent activities of her | F | 248 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | PLE CONSTRUCTION | · , | (X3) DATE SURVEY COMPLETED C 02/23/2017 | |
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| | | 345050 | B. WING _ | | | | |
| | NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CO 1721 BALD HILL LOOP MADISON, NC 27025 | • | 212012011 | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC' | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 248 | decision making a severe dementia. would display app The interventions activities (social e music and spiritual procedure prior to into manageable sat a time and allow verbalize needs. At the care plan was depression character and feeling bad al resident would im and symptoms of The intervention in attend group activities demonstrating desprovide 1:1 session reorientation. An observation of secured unit on 2/2 activities were schill:00 AM, bible stand 3:30 PM noome. The activities the facility include AM, bible study, 3 church. During an observation of seated in the day for the 10:30 AM alimber up activity activity staff on the | cterized by deficit in memory, and thought process related to The goal included resident ropriate response to situation. include encourage small group vents, pet therapy, listening to all events), explain each activity beginning it, break activities subtask and give on instruction of resident sufficient time to Another problem identified on Feelings of sadness, anxiety, cterized by ineffective coping bout herself. The goal included prove mood state with no signs depression, anxiety or sadness. Included encourage resident to dities, offer activities of which are interest, praise/reward for sired mood and behavior and ons with resident for the activities calendar on the 122/17 revealed the following diduled: 10:30 AM, limber up, and y, 2:30 PM current events alle ball and 4:00 PM sing with calendar in other sections of d 10:30 AM, limber up 11:00 and T:00 PM, bingo and T:00 PM. The section of the secured unit on the the secured unit on the secured unit on the | F 2 | 48 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED C 02/23/2017 | |
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| | | 345050 B. WING | | | | | |
| | NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025 | | | |
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| F 248 | Continued From pag | e 18 | F 24 | 48 | | | |
| | the scheduled activity the hall was bible stu occur. Resident #142 and there was no alt designated activity sunit. During an observation scheduled activity for current events and the activity staff was not was no alternate act. During an observation noodle ball was scheduled ball was scheduled ball was scheduled in the day alternate activity prostaff was not present. During an observation staff was not present. During an observation was done with me. This activity for with me. This activity observation was done Resident #142 remained inner meal was set activity provided. | on on 2/22/17 at 3:00 PM eduled on the secured unit. occur. Resident #142 room and there was no wided. The designated activity ton the unit. on on 2/22/17 at 4:00 PM, the resecured unit was sing wided not occur. A continuous see 4:00 PM to 5:00 PM and sined in the day room until the up, there was no alternate | | | | | |
| | services. This activity residents were not in cancelled. Residents asked by surveyor. | y did not occur and the iformed the activity was that were asked up were The residents that were up ere informed the activity was | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345050 | 345050 B. WING | | | C 02/23/2017 | | |
| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COL 1721 BALD HILL LOOP MADISON, NC 27025 | DE | 02/25/2011 | | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIAT | (X5) COMPLETION DATE | | |
| F 248 | During an interview of Assistant Director of the activities assistant providing activities for unit. The ADON indicactivities should have activity schedule. During interview on 2 Activity Assistant (AA responsible for the activity AS activity Assistant (AA responsible for the activity AS activity A | en 2/22/17 at 5:42 PM, the Nursing (ADON) stated that at #1 was responsible for residents on the secured ated the designated coccurred in accordance to at #1), stated she was ctivities on the secured unit. Activities that were are not done in lendar and there were no naddition, there was no evide coverage when she cheduled events could not ar stated when an outside led and it was cancelled the pected to let the residents mate activity. | | | | | | |
| | to the calendar and/o when scheduled actival administrator and DC assigned to the secu provided the activities calendar. If the volun cancelled the resider DON confirmed that a church program did r confirmed there was place to monitor to el | uled activities in accordance or provide alternate activities writies were cancelled. The DN indicated that AA#1 was red unit and should have as scheduled on the daily teers or outside resources at needed to be notified. The scheduled 7:00PM not happen on 2/22/17. DON no designated system in asure the activities were the building. The DON | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING _ | | | C 02/23/2017 |
| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 1721 BALD HILL LOOP MADISON, NC 27025 | | 02/23/2017 |
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| F 248 | Continued From pag | e 20 | F 2 | 248 | | |
| | activities be impleme | ectation that alternate inted when there was a ange and the resident be es. | | | | |
| | Activity Assistant (AA responsible for the activities. The AA #2 were responsible for ready for activities. A occurred on the assist the schedule and the rooms as assigned. scheduled activities I the activity did not occurred when the occurred when the occurred when the occurred activities I the activity did not occurred when the occu | on 2/23/17 at 11:11AM, the (a) #2 indicated that she was ctivities on the halls and 1:1 stated the nursing assistants getting residents up and (b) A#2 reported activities had gned hall in accordance to a 1:1were done in resident (c) When asked about specific like bible study she confirmed for the day. The AA#2 tutside programs cancelled and then staff would let the further stated she was tup plan for the 500/600 hall | | | | |
| | when the assigned a present on the unit. identified by either A | ctivities person was not The back-up plan was not A #1 or AA #2. | | | | |
| | diagnoses included of schizophrenia. The Mated 12/27/16, code assistance with partic Review of the activity 12/16/16, revealed Rincluded arts/crafts, sigames) religious (hysservices), television, cooking/baking. Review of the activity documented the residuated arts/crafts. | v assessment form dated desident #145 interest sports, games(board/card mns sing and worship woodworking and v note dated 12/6/16, dent actively participated in | | | | |
| | | ents, social visits and ependent activities of his | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|--|-------------|-------------------------------|--|
| | | 345050 | B. WING | B. WING | | C 02/23/2017 | |
| NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP COD 1721 BALD HILL LOOP MADISON, NC 27025 | | | |
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| F 248 | Continued From pag | | F 2 | 48 | | | |
| | would encourage out provide 1:1 program participate in structure of her choice. Review of the care puthe problem as a children functioning characted decision making and severe dementia and included resident wore response to situation encourage small group et therapy, listening events), explain each beginning it, break a subtask and give on allow/encourage resultance An observation of the secured unit on 2/22 activities were scheed 11:00 AM, bible study and 3:30 PM noodle me. The activities cathe facility included AM, bible study, 3:00 church. During an observation of the 10:30 AM activity staff on the under the pactivity did activity staff on the unwere providing care. | active participation. Staff to froom group events, as needed and actively red out of room group events of an dated 1/12/17, identified ronic decline in intellectual rized by deficit in memory, thought process related to dischizophrenia. The goal rould display appropriate in. The interventions included roup activities (social events, go to music and spiritual in activity procedure prior to activities into manageable re instruction at a time and rident to make choices. The activities calendar on the round of | | | | | |

| ` ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDIN | (X3) DATE SURVEY COMPLETED | | | | |
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| | | 345050 | B. WING _ | | | C 02/23/2017 | | |
| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | | |
| F 248 | the hall was bible stroccur. Resident #14 and there was no alt designated activity sunit. During an observation scheduled activity for current events and the activity staff was not was no alternate activity staff was not alternate activity did not remained in the day alternate activity prostaff was not present buring an observation was dorn Resident #145 remained in the activity observation was dorn Resident #145 remained in the activity observation was dorn Resident #145 remained in the activity observation was dorn Resident #145 remained in the activity provided. During an observation was set activity provided. During an observation was dorn Residents were not in cancelled. Residents asked by surveyor. Was asked if they we cancelled and many During an interview Assistant Director of the strong and th | dy. This activity did not 5 remained in the day room ternate activity provided. The staff was not present on the on on 2/22/17 at 2:30 PM, the or the secured unit was his activity did not occur. The present on the unit and there initiativity offered. On on 2/22/17 at 3:00 PM eduled on the secured unit. occur. Resident #145 room and there was no wided. The designated activity at on the unit. On on 2/22/17 at 4:00 PM, the or the secured unit was sing yield not occur. A continuous he 4:00 PM to 5:00 PM and hined in the day room until the rup, there was no alternate On on 2/22/17 at 7:00 PM, the on the hall was church by did not occur and the nother than the hall was church by did not occur and the nother than the activity was so that were asked up were one informed the activity was server informed the activity was server informed the activity was | F2 | 248 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING _ | | | C 02/23/2017 |
| | ROVIDER OR SUPPLIER CREEK NURSING AND F | REHABILITATION CENTER | • | STREET ADDRESS, CITY, STAT 1721 BALD HILL LOOP MADISON, NC 27025 | E, ZIP CODE | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFII TAG | X (EACH CORRECT CROSS-REFERENC | PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY) | |
| F 248 | unit. The ADON indicactivities should have activity schedule. During interview on 2. Activity Assistant (AA responsible for the ac AA#1 confirmed the ascheduled for 2/22/17 accordance to the cal alternates provided. It system in place to prowas sick or when a sobe done. AA#1 furthe program was schedul activities staff was ex know and do an alternated the expectation to provide the scheduled to the calendar and/owhen scheduled activities calendar. If the volunt cancelled the residen DON confirmed that the church program did not confirmed there was applace to monitor to er being provided within stated it was her expectation to provide the was applace to monitor to er being provided within stated it was her expectativities be implementation. | residents on the secured ated the designated occurred in accordance to 723/17 at 10:49 AM, the #1), stated she was tivities on the secured unit. Indivities that were represented when an outside ed and it was cancelled the pected to let the residents hate activities in accordance or provide alternate activities were cancelled. The N indicated that AA#1 was ed unit and should have as scheduled 7:00PM of happen on 2/22/17. DON no designated system in source the building. The DON ectation that alternate activities were the building. The DON ectation that alternate activities were the building. The DON ectation that alternate activities were the building. The DON ectation that alternate activities were the building. The DON ectation that alternate activities were and ange and the resident be | F2 | 248 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|------|-------------------------------|----------------------------|
| | | 345050 | B. WING _ | | | 02/2 | 3/2017 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | CODE | <u> </u> | <u></u> |
| IACORIC | CDEEK NUBSING AND | DELIABII ITATION CENTER | | 1721 BALD HILL LOOP | | | |
| JACOB S | CREEK NURSING AND | REHABILITATION CENTER | | MADISON, NC 27025 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | | (X5) COMPLETION DATE |
| F 248 | Activity Assistant (A/responsible for the a activities. The AA #2 were responsible for ready for activities. A occurred on the assist the schedule and the | on 2/23/17 at 11:11AM, the A) #2 indicated that she was ctivities on the halls and 1:1 stated the nursing assistants getting residents up and AA#2 reported activities had gned hall in accordance to a 1:1 were done in resident When asked about specific | F 2 | 248 | | | |
| | scheduled activities the activity did not or indicated when the country usually called a resident's know. She unaware of the back when the assigned a | like bible study she confirmed ccur for the day. The AA#2 butside programs cancelled nd then staff would let the further stated she was -up plan for the 500/600 hall activities person was not The back-up plan was not | | | | | |
| | diagnoses included of cognitive communication Data Set (MDS) date #192 needed assistation activities. Review of the activity 12/13/16, revealed Fincluded arts/crafts, and card games) reliand worship services and reading. Review of the activity documented the resiout of room group expectations are socialized with other of room group event needed | dementia, anxiety and ation deficit. The Minimum ed 2/16/16, coded Resident ance with participation in assessment form dated Resident #192 interest sports, games(bingo, word gious (bible study, devotions s), television, socials, music y note dated 12/13/16, dent actively participated in vents, social of her choice. need redirection at times and . Staff would encourage out s, provide 1:1 program as | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING _ | | | | 23/2017 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CC | DDE | 1 02/ | 25/2017 |
| JACOB'S | CREEK NURSING AND I | REHABILITATION CENTER | 1721 BALD HILL LOOP MADISON, NC 27025 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 248 | functioning character decision making and severe dementia. The would display approp The interventions incl group activities (social listening to music and each activity procedu activities into manage instruction at a time at time to verbalize need An observation of the secured unit on 2/22/activities were schedu 11:00 AM, bible study and 3:30 PM noodle Ime. The activities cal the facility included 10 AM, bible study, 3:00 church. During an observation 2/22/17 at 10:30 AM, seated in the day roo for the 10:30 AM activitimber up activity did activity staff on the ur were providing care to During an observation the scheduled activity the hall was bible study. | price decline in intellectual sized by deficit in memory, thought process related to be goal included resident riate response to situation. Unded encourage small all events, pet therapy, it spiritual events), explain re prior to beginning it, break eable subtask and give on and allow resident sufficient dis. The activities calendar on the 17 revealed the following unled: 10:30 AM, limber up, 17, 2:30 PM current events of all and 4:00 PM sing with endar in other sections of 10:30 AM, limber up 11:00 PM, bingo and 7:00 PM The on the secured unit on the following resident was mich Resident #192, waiting with the occur. There was no not and the nursing assistants to the other residents. The on 2/22/17 at 11:00 AM, of for the secured unit and on dy. This activity did not | F2 | 248 | | | |
| | and there was no alted designated activity strunit. | remained in the day room ernate activity provided. The aff was not present on the n on 2/22/17 at 2:30 PM, the | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING _ | | | C 02/23/2017 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | CODE | 02/23/2017 | |
| IACORIS | CDEEK MIIDSING VND I | REHABILITATION CENTER | | 1721 BALD HILL LOOP | | | |
| JACOB 3 | CREEK NORSING AND I | CENABILITATION CENTER | | MADISON, NC 27025 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE THE APPROPRIA | DATE | |
| F 248 | Continued From page | e 26 | F 2 | 248 | | | |
| | scheduled activity for current events and th | the secured unit was is activity did not occur. The present on the unit and there | | | | | |
| | noodle ball was sche This activity did not o remained in the day r | oom and there was no rided. The designated activity | | | | | |
| | scheduled activity for with me. This activity observation was done Resident #192 remain | n on 2/22/17 at 4:00 PM, the the secured unit was sing did not occur. A continuous e 4:00 PM to 5:00 PM and ned in the day room until the up, there was no alternate | | | | | |
| | scheduled activity on services. This activity residents were not in cancelled. Residents asked by surveyor. T | did not occur and the formed the activity was that were asked up were the residents that were up re informed the activity was | | | | | |
| | Assistant Director of the activities assistant providing activities founit. The ADON indic activities should have activity schedule. During interview on 2 Activity Assistant (AA | e occurred in accordance to /23/17 at 10:49 AM, the | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING _ | | | C 2/23/2017 | |
| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COI 1721 BALD HILL LOOP MADISON, NC 27025 | | 212312011 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 248 | alternates provided. system in place to provided. system in place to provide a sick or when a sick or when a sick or when a sick of the staff was expectation and the stated the expectation to provide the sched to the calendar and when scheduled activation and provided to the secuprovided the activities calendar. If the voluring an interview of the calendar and provided the secuprovided the activities calendar. If the voluring signed to the secuprovided the activities calendar. | activities that were 7 were not done in alendar and there were no In addition, there was no rovide coverage when she scheduled events could not er stated when an outside uled and it was cancelled the expected to let the residents | F2 | 248 | | | |
| | church program did confirmed there was place to monitor to e being provided within stated it was her expactivities be impleme scheduled activity chnotified of the change. During an interview of Activity Assistant (Avresponsible for the activities. The AA #2 were responsible for ready for activities. | the scheduled 7:00PM not happen on 2/22/17. DON no designated system in insure the activities were in the building. The DON pectation that alternate ented when there was a hange and the resident be es. In 2/23/17 at 11:11AM, the A) #2 indicated that she was activities on the halls and 1:1 is stated the nursing assistants regetting residents up and AA#2 reported activities had gned hall in accordance to | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING | | | C 02/23/2017 |
| | ROVIDER OR SUPPLIER | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE 1721 BALD HILL LOOP MADISON, NC 27025 | , ZIP CODE | 02/25/2017 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCE | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECTIV CROSS-REFERENCE | AN OF CORRECTION YE ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY) | (X5) COMPLETION DATE |
| F 248 | rooms as assigned. scheduled activities the activity did not of indicated when the control they usually called a resident's know. She unaware of the back when the assigned a present on the unit. identified by either A g. Resident #107 was diagnoses included a cognitive communicated Data Set (MDS) date #107 needed assistated activities. Review of the activity 7/25/16, revealed Rearts/crafts, sports, gareligious (bible study services), television, Review of the care pathe problem as alterarecreation characteri involvement, lack of cognitive impairment. The goal included restructured sensory, sactivities at least 1-3 activities at least 1-3 activities at least 1-3 activities. | e 1:1were done in resident When asked about specific like bible study she confirmed ccur for the day. The AA#2 butside programs cancelled and then staff would let the e further stated she was -up plan for the 500/600 hall activities person was not The back-up plan was not A #1 or AA #2. Its admitted on 7/31/15. The dementia, depression and action deficit. The Minimum and 11/16/16, coded Resident ance with participation in by assessment form dated desident #107 interest included ames(bingo/card games) and devotions and worship socials, music and reading. Italian dated 11/28/16, identified action in supervised/organized | F | 248 | (CIENCT) | |
| | engage resident in g individualized activiti auditory, mental, tac stimulations, offer or program for intellecti | roup activities, 1:1 in room es programming -specify tile, visual and/or social n-going structured activity ual stimulation, offer activity vard specific interest/needs | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | , , | (X3) DATE SURVEY COMPLETED | | |
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| | | 345050 | B. WING | | | C 02/23/2017 | | |
| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COL 1721 BALD HILL LOOP MADISON, NC 27025 | • | 02/23/2017 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | | |
| F 248 | Continued From pag | e 29 | F 2 | 48 | | | | |
| | 1:1 in room programs room group events. So out of bed. During 1: to contact from other laughs. Staff would events, provide 1:1 pencourage out of room Review of the activitia 300 hall bulletin boar activities were scheded 11:00 AM, bible study PM Church. The activities and ther done at 10:30 AM and occurred at 11:00 AM, was no church serviced During an observation 10:30 AM, Resident activity room. Resident #107 remains activity staff was not During an interview of Nursing Assistant Na activities assistant is for getting residents assist when asked, howere doing care they transporting resident reported that some of occur. NA #4 reported | dent had been provided with s, but had not joined out of She had not been observed 1 events resident responded s with verbal gibberish or encourage out of room group program as needed and am group events. Les calendar 2/22/17 on the red revealed the following uled: 10:30AM, Limber up, y, 3:00 PM bingo and 7:00 vities room was checked on the were no activities being and no bible study activity M, Bingo did occur. There we within the building. Len on the hall on 2/22/17 at #107 was not present in the ent #107 remained in bed. Len on 2/22/17 at 11:00 AM, and in bed. The designated | | | | | | |

| , , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING | | | (| |
| NAME OF D | ROVIDER OR SUPPLIER | 3-3000 | 5: 11::10 | STREET ADDRESS, CITY, STATE, ZIP (| CODE | 02/ | 23/2017 |
| NAME OF FI | NOVIDER OR SUFFLIER | | | 1721 BALD HILL LOOP | JODE | | |
| JACOB'S | CREEK NURSING AND I | REHABILITATION CENTER | | MADISON, NC 27025 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BI THE APPROPRIA | | (X5) COMPLETION DATE |
| F 248 | Continued From page bed most of the time. During an interview of indicated that Reside bed for activities due that activities was residents to activities they were not performalso reported that act on a consistent basis had been so short in NAs and restorative ado more residents that During an interview of indicated that the Act for getting resident to NAs would assist whe shortage of staff and done, NAs had a difficactivities. NA #5 state ran in accordance to some were skipped of During an interview of the control of the co | e 30 n 2/23/17 at 9:25AM, NA, #6 nt #107 did not get out of to lack of staff. NA reported sponsible for transporting and NA would assist when ning other care duties. NA #6 ivities were not being done . NA #6 also stated staffing the past few months and aides RAs were expected to an they were able on a shift. n 2/23/17 at 9:00 AM, NA #5 ivities staff was responsible activities. She explained the en asked, but due to trying to get all the care cult time assisting with ad that not all activities was what ' s on the schedule and | | | | ALE. | |
| | stated the expectation to provide the scheduled active when scheduled active administrator and DC assigned to the security provided the activities calendar. If the voluncancelled the residen | n was for the activities staff aled activities in accordance or provide alternate activities writies were cancelled. The N indicated that AA#1 was red unit and should have as scheduled on the daily teers or outside resources to needed to be notified. | | | | | |
| | church program did n confirmed there was | ot happen on 2/22/17. DON no designated system in sure the activities were | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | l l | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345050 | B. WING _ | | | C 02/23/2017 | | |
| | ROVIDER OR SUPPLIER CREEK NURSING AND I | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COE 1721 BALD HILL LOOP MADISON, NC 27025 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | | |
| F 248 F 281 SS=D | stated it was her experience activities be implement scheduled activity chanotified of the change 483.21(b)(3)(i) SERV PROFESSIONAL STATE (b)(3) Comprehensive The services provided | the building. The DON ectation that alternate nted when there was a range and the resident be s. ICES PROVIDED MEET ANDARDS | F2 | | | 3/19/17 | | |
| | must- (i) Meet professional This REQUIREMENT by: Based on observation interviews the facility medication as prescrit observed for unnecessions and the second served for unnecessions and the second served for unnecessions and the second served for unnecession for unnecessions and the second served for unnecession for the second | standards of quality. is not met as evidenced n, record review and staff failed to administer a bed for 1 of 5 residents sary medications. dmitted to the facility on acluded, in part, dementia, on. um Data Set (MDS) dated resident was alert and eived 7 doses of an es of an antidepressant. plan revealed an updated gs of sadness, anxiety and ventions to include, as as ordered and monitor | | F281 On 2/22/2017, the director of (DON) corrected medication administration times for Resimeet professional standards administering medications as On 2/28/2017, the DON, assimated of nursing (ADON), and qualimprovement (QI) nurse com 100% audit on all residents administration record (MAR) accuracy of medication adminiculde Resident #144. No owere identified by the DON, Anurse on 2/28/2017. On 3/10/2017, the staff facility a 100% in-service for all nurse medication aides regarding a spacing of time specific medication. | dent #144 to to include s prescribed. istant director ity pleted a medication times for nistration, to other issues ADON, QI ator initiated ses and appropriate | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | , , , | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING | | | C 2/23/2017 |
| | ROVIDER OR SUPPLIER CREEK NURSING AND I | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COL 1721 BALD HILL LOOP MADISON, NC 27025 | | 2/20/2011 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 281 | mouth every 8 hours. recorded on the phys 2:00 pm and 12:00 at to 2:00 pm was 5 hou pm to 12:00 am was. A review of the Medic (MAR) revealed there milligrams by mouth a scheduled hours for the as 9:00 am, 4:00 pm time from 9:00 am to the dose from 4:00 pm. An interview was con 2/22/17 at 3:40 pm. In the been giving the medic written on the MAR a was not scheduled even an interview with the on 2/22/17 at 5:15 pm. MAR should have been the DON confirmed the written incorrectly and the DON reported the scheduled for 9:00 are an interview with the revealed her expectat transcribe the physicin Medication Administration. | an 's order written on order for Ativan (a exiety) 0.5 milligrams by The times that were ician 's order was 9:00 am, m. The dose from 9:00 am ars and the dose from 2:00 10 hours. The dose from 9:00 am ars and the dose from 2:00 10 hours. The dose from 2:00 am ars and the dose from 2:00 am ars an order for Ativan 0.5 every 8 hours. The he medication was recorded and 12:00 am. The dose 4:00 pm was 7 hours and m till 12:00 am was 8 hours. The dose 4:00 pm was 7 hours and m till 12:00 am was 8 hours. The dose 4:00 pm was 7 hours and m till 12:00 am was 8 hours. The dose 4:00 pm was 7 hours and m till 12:00 am was 8 hours. The dose 4:00 pm was 7 hours and m till 12:00 am was 8 hours. The dose 4:00 pm was 7 hours and m till 12:00 am was 8 hours. The dose 4:00 pm was 7 hours and m till 12:00 am was 8 hours. The dose from 9:00 am was 9:00 am and 1:00 am. The dose from 9:00 am and 1:00 am. | F 28 | 3/19/2017, no nurse or medic will be allowed to work until the scompleted. This in-service to the new employee orientat nurses and medication aides. The DON, ADON, and/or were manager will audit all orders specific directions to ensure the are being administered as protimes a week for 12 weeks. The documented on the Medic Audit tool. The results of the audits will be the DON at the monthly Quantity Assurance meeting for 3 more further review and recommental to the service of the | he in-service will be added cion for all ekend nurse with time medications escribed 5 This audit will cation Error the presented quality onths for | |
| F 315 SS=D | 483.25(e)(1)-(3) NO (RESTORE BLADDER | CATHETER, PREVENT UTI, R | F 3 | 15 | | 3/19/17 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING | | | C 02/23/2017 | |
| | ROVIDER OR SUPPLIER CREEK NURSING AND F | REHABILITATION CENTER | | 17 | TREET ADDRESS, CITY, STATE, ZIP CODE 721 BALD HILL LOOP ADISON, NC 27025 | 1 021 | 23/2017 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 315 | continent of bladder a | nsure that resident who is nd bowel on admission assistance to maintain | F | 315 | | | |
| | | or her clinical condition is continence is not possible | | | | | |
| | | urinary incontinence, based prehensive assessment, the lat- | | | | | |
| | indwelling catheter is | ers the facility without an not catheterized unless the dition demonstrates that ecessary; | | | | | |
| | indwelling catheter or is assessed for removas possible unless the | ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary | | | | | |
| | receives appropriate | incontinent of bladder creatment and services to infections and to restore ent possible. | | | | | |
| | on the resident's com facility must ensure the incontinent of bowel r | eceives appropriate s to restore as much normal | | | | | |
| | This REQUIREMENT by: | is not met as evidenced n, staff interviews and | | | F315 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|---|---|--|-------------------------------|--|
| | | 345050 | B. WING | | C | | | |
| NAME OF P | ROVIDER OR SUPPLIER | 0.0000 | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | 02 | 123/2017 | |
| | 10115211 011 001 1 2.2.1 | | | | 1 BALD HILL LOOP | | | |
| JACOB'S | CREEK NURSING AND | REHABILITATION CENTER | | | DISON, NC 27025 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE | |
| F 315 | Continued From page | ge 34 | F3 | 315 | | | | |
| | catheter anchor to s residents with an ind (Resident #102). | | | | On 2/22/2017, the charge nurse place Secure Cath securing anchor, tubing I strap and catheter privacy cover on Resident #102 Foley catheter to provide a catheter anchor and privacy the indwelling Foley catheter. | eg | | |
| Resident #102 was admitted on 3/13/13. The diagnoses included dementia, benign prostatic hypertrophy and bladder outlet obstruction. The most recent Minimum Data Set (MDS) dated 1/25/17, revealed he was incontinent at all times of bladder. Review of physician 's order dated 11/29/16, revealed the catheter site and securement of the | | | | On 2/22/2017, the charge nurse completed a 100% audit on all resider with indwelling Foley catheters, to incl Resident #102, to ensure catheter anchors were in place and privacy covwere in place. No other issues were identified by the charge nurse on 2/22/2017. | | | | |
| | revealed the catheter site and securement of the catheter should be monitored daily for proper placement. Review of the care plan dated 1/15/17, revealed Resident #102 had an indwelling catheter due to bladder neck outlet obstruction. The goal included Resident #102 would be free from urinary tract infection. The intervention included the drainage tubing was secured with anchoring device, i.e., leg strap, to prevent tension or accidental removal. The indwelling urinary catheter would be monitored and secured for proper placement daily. During an interview on 2/22/17 at 11:24AM, Nurse #4 confirmed the indwelling catheter was not secured with a leg strap and not covered with a privacy bag. Nurse #4 stated the catheter should be covered with a privacy bag and/or kept | | | | On 3/10/2017, the staff facilitator initial a 100% in-service of all nursing staff regarding ensuring residents with indwelling Foley catheters have a securing anchor and privacy bag in planting the allowed to work until the in-service completed. This in-service will be acted to the new employee orientation for al nursing employees. On 3/14/2017, the quality improvement (QI) nurse placed a reminder on the Medication Administration Records of residents with indwelling Foley catheter for nurses and/or medication aides to ensure placement of securing anchors and/or leg straps every shift. | ace. ber vice dded I nt | | |
| | covered under cloth During an observati | | | | Audits will be conducted by Director o Nursing, Assistant Director of Nursing and/or Quality Improvement nurse 5 ti a week for 12 weeks to ensure Secure | mes | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING | B. WING | | C 02/23/2017 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | | J2/25/2017 | |
| | | | | 1721 BALD HILL LOOP | | | |
| JACOB'S | CREEK NURSING AND | REHABILITATION CENTER | | MADISON, NC 27025 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 315 | Continued From pag | e 35 | F 31 | 5 | | | |
| F 315 | room with a full indwe underneath the whee catheter was pulled to Resident #102's particles as seen hanging under without a privacy bag. During an interview and the catheter would have a leg strap and the catheter would have alresident's clothing. Notinger bag and the cand secured to reside NA#3 a leg strap to be considered to the state of the secure of the secur | elling catheter hanging elchair. The indwelling hrough a hole in the front of ints. The catheter could be the wheelchair uncovered g or a leg strap. and observation on 2/22/17 at cated the catheter did not she had never seen it where ang from a hole in the formally there would be a atheter would be covered ent's leg. Nurse #4 handed be applied to the resident. and 2/22/17 at 11:35AM, NA#2 resident's clothing had the catheter would be pulled to the resident's leg not seen a leg strap and was ent would pull the catheter end further stated that the end a privacy bag or secured esident's clothing. and 2/22/17 at 1:47PM, the DON) stated the wound care to check all resident pasis to ensure they were did privacy provided. | F 31 | Cath (catheter anchor), and p is in place for residents with a catheter. This audit will be do on the Foley Catheter Audit to The results of the audits will by the Director of Nursing at Quality Assurance meeting for further review and recommendations. | a Foley ocumented cool. Doe presented the monthly or 3 months | | |
| | responsible for check indwelling catheters anchors and/or leg s | ndicated that she was king and monitoring the to ensure they were secured, traps were provided and use of privacy bag or | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--|--|--|--|----------------------------|
| | | 345050 | B. WING | | | | 23/2017 |
| NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER | | • | 17 | TREET ADDRESS, CITY, STATE, ZIP CODE 721 BALD HILL LOOP ADISON, NC 27025 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 315 | | e 36 rse #6 indicated she would e treatment administration | F: | 315 | | | |
| F 371 SS=E | January and February catheter site weekly a of the catheter for pro | | F: | 371 | | | 3/19/17 |
| | considered satisfactor authorities. (i) This may include for from local producers, | rom sources approved or ry by federal, state or local cood items obtained directly subject to applicable State | | | | | |
| | facilities from using prigardens, subject to consafe growing and food (iii) This provision does | es not prohibit or prevent roduce grown in facility compliance with applicable | | | | | |
| | | , distribute and serve food in essional standards for food | | | | | |
| | foods brought to residusitors to ensure safe handling, and consum | egarding use and storage of dents by family and other e and sanitary storage, nption. is not met as evidenced | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | MULTIPLE CONSTRUCTION JILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING | | 0. | C | |
| NAME OF P | ROVIDER OR SUPPLIER | 0.0000 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 0/ | 2/23/2017 | |
| | | | 1721 BALD HILL LOOP | | | | |
| JACOB'S | JACOB'S CREEK NURSING AND REHABILITATION CENTER | | | MADISON, NC 27025 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 371 | Continued From pag | e 37 | F 37 | 1 | | | |
| | by: Based on observation the facility failed to law alk-in freezer, dry serfrigerator and discissionage and nourish. Findings included: 1a. An observation of 2/20/17 at 12:01 PM in a Ziploc bag with written on it. No oper expiration date was about the control of the 2/20/17 at 12:01 PM in a Ziploc bag with written on it. No oper expiration date was about the control of 2/20/17 at 12:05 PM opened frozen veget the Dietary Manage contained frozen confrozen rhubarb that with the control of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 12:08 PM unidentified pieces of 2 a. An observation of 2/20/17 at 2 a. An observat | on and facility staff interviews, abel and date foods in the storage and nourishment and expired food in the dry ment refrigerator. If the dry storage room on revealed two white packets 'Cheesy sauce mix, 11/8/16" ned date, use by date or noted. If the walk-in refrigerator on revealed three blue bags of tables that were not labelled. If the walk-in freezer on revealed a bag of four frozen if meat that were not labelled. | | F371 On 2/22/2017, the dietary manag removed and discarded 3 unlabe bags of opened frozen vegetable were in the walk-in refrigerator, a unidentified pieces of meat from the walk-in freezer, 2 white packets in Ziploc bag with cheesy sauce mix written on it from the dry storage and 3 white packets in a Ziploc backesy sauce mix, 1/21/17 writte from the dry storage room. On 2 the geriatric care assistant removed discarded one cup of hot chocola cups of coffee, 3 nutrition suppler with labels indicating resident nare date, 2/20/2017 and Refused written labels, 2 green bottles contain liquids that looked like soda with labels, 2 quart cartons of ice-creat packs of ready to eat frozen dinner freezer with no labels in accordar professional standards for food seafety. On 3/14/2017, the dietary manage complete a 100% audit of dry stowalk-in refrigerator, and walk-in freensure all items were labeled, danot expired. No other issues were identified by the dietary manager 3/14/2015. On 3/14/2017, the gecare assistant completed a 100% all nourishment room refrigerators ensure all items were labeled with | led blue s that bag of 4 the n a k, 11/8/16 room, ag with n on it //22/2017, red and te, 3 ments mes with tten on ning no am and 2 ers in the nce with ervice er rage, reezer to ted, and ee on riatric audit of s to | | |
| | | date: 2/20/17 and "Refused" | | and resident name, and no items expired. No other issues were id by the geriatric care assistant on | were | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBED: | |) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345050 | B. WING_ | | | | C / 23/2017 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | 02 | 123/2017 | |
| IVAIVIL OI II | TOVIDER OR OUT FEET | | | | 21 BALD HILL LOOP | | | |
| JACOB'S CREEK NURSING AND REHABILITATION CENTER | | | | | | | | |
| | | | | IVI | ADISON, NC 27025 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 371 | Continued From pag | e 38 | F3 | 371 | | | | |
| | on 2/22/17 at 4:33 P containing liquids that | the nourishment refrigerator M revealed two green bottles at looked like soda with no | | | 3/14/2017. On 3/10/2017, the staff facilitator initiat | ed | | |
| | labels. c. An observation of | the nourishment refrigerator | | | a 100% in-service of all nurses and nursing assistants regarding proper storage and labeling of foods in | | | |
| | | M revealed two quart cartons | | | nourishment refrigerators in accordance | е | | |
| | | packs of ready to eat frozen | | | with professional standards for food | | | |
| | dinners in the freeze | r with no labels. | | | service safety. After 3/19/2017, no | | | |
| | | | | | nursing staff member will be allowed to | 1 | | |
| | During an interview with the Dietary Manager | | | | work until the in-service is completed. | | | |
| | | :28 AM, she stated that the | | | 3/10/2017, the staff facilitator initiated a | a | | |
| | _ | ators were checked once | | | 100% in-service of all dietary staff | _ | | |
| | | e indicated that frozen dinners | | | regarding proper storing and labeling of | | | |
| | | art cartons were not served | | | food in dry storage, walk-in refrigerator | | | |
| | _ | stated that the activity | | | and walk-in freezer in accordance with | | | |
| | | nay have placed the food in | | | professional standards for food service | | | |
| | | also stated that resident's | | | safety. After 3/19/2017, no dietary staff | | | |
| | | oring food for the resident | | | member will be allowed to work until th | е | | |
| | | el these foods. She indicated | | | in-service is completed. | | | |
| | | nd supplements should be | | | A | 4 | | |
| | | en and not stored in the | | | Audits on dry storage, walk-in refrigera | | | |
| | refrigerator. She stat | | | | and walk-in freezer storage and labelin will be conducted by the dietary manage | | | |
| | | staff return refused drinks or | | | and/or assistant dietary manager 5 time | | | |
| | | tchen and staff not store enourishment refrigerator. | | | a week for 12 weeks. This audit will be | | | |
| | · | nat activities staff should label | | | documented on the Dietary Storage an | | | |
| | | ne refrigerator. She stated | | | Labeling Audit tool. Audits on | u | | |
| | | station that all dietary staff | | | nourishment refrigerators for storage a | nd | | |
| | | pired foods appropriately. | | | labeling will be conducted by the gerial | | | |
| | label and discard exp | pired roods appropriately. | | | care assistant and/or director of nursing | | | |
| | During an interview v | with the Administrator on | | | times a week for 12 weeks. This audit | _ | | |
| | _ | she stated that it was her | | | be documented on the Nourishment | | | |
| | | ds were labelled appropriately | | | Refrigerator Audit tool. | | | |
| | | ght in by family members that | | | - G | | | |
| | | purishment refrigerator. | | | The results of the audits will be presen by the director of nursing and/or the | ted | | |
| | | | | | dietary manager at the monthly Quality | | | |
| | | | | | Assurance meeting for 3 months for | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 345050 | B. WING | | C 02/23/2017 | | |
| NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025 | | | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION | | |
| F 371 | Continued From page | e 39 | F 37 | | S. | | |
| | | | | | | | |