C C STREET ADDRESS, GTV, STATE, JP COCC TAGE SCREEK NURSING AND REHABILITATION CENTER STREET ADDRESS, GTV, STATE, JP COCC TAGE SCREEK NURSING AND REHABILITATION CENTER OWING CORSUMPLIES DEPONENCES TO THE APPROPRIATE OWING CORSUMPLIES PERCENTION CORSUMPLIES F 000 INITIAL COMMENTS F 812 F 000 SEC CORSUMPLIES F 812 SEC CORSUMPLIES F 812 SEC CORSUMPLIES F 000 F 000 F 000 F 000		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANALE OF PROVIDER OR SUPPLIER INTEGENTION OF THE CONTRACT OF THE			345050	B. WING		
DACOBS CREEK NURSING AND REHABILITATION CENTER MADISON, NC 27025 (X4) U PRETX NOC SUMMARY STREMENT OF DEFICIENCIES (Exclusioned in the exception of PTUL (Exclusioned in the exclusion of PTU	NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	02/22/2018
Print TAG (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION) PRE/IV TAG (EACH CORFICENCE) OF INHUME ACTION SHOULD BE DEFICENCY) COMMITMENT INFORMATION F 000 INITIAL COMMENTS F 000 F 000 F 812 F 000 3/22/18 F 812 F 001 rocurrent Store/Prepare/Serve-Sanitary SS=E F 812 F 000 F 812 5/483.60(i)(1/2) S 483.80(i)(1/2) S 483.80(i)(1/2) F 812 5/483.80(i)(1/2) S 483.80(i)(1/2) S 483.80(i)(1/2) <td< td=""><td>JACOB'S</td><td>CREEK NURSING AND F</td><td>REHABILITATION CENTER</td><td></td><td></td><td></td></td<>	JACOB'S	CREEK NURSING AND F	REHABILITATION CENTER			
No deficiencies were cited as a result of the complaint investigation survey for Event #THU411 conducted on 02/22/18. Set 5000000000000000000000000000000000000	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIO
complaint investigation survey for Event #THU411 conducted on 02/22/18. F 812 Food Procurement.Store/Prepare/Serve-Sanitary F 812 SS=E CFR(s): 483.60(i)(1)(2) \$483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. \$483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. \$483.60(i)(2) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. \$483.60(i)(2) - Store, prevent facility from local producers, subject to applicable State and local laws or regulations. \$483.60(i)(2) - Store, prepare, distribute and sare food in accordance with applicable safe growing and food-handling practices. \$483.60(i)(2) - Store, prepare, distribute and sarve food in accordance with profication as serve food in accordance with profication as and proses this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain flore. With an allegation of compliance. The Findings included: The Plan of Correction is submitted as a written allegation of compliance.	F 000	INITIAL COMMENTS		F 000		
SS=E CFR(s): 483.60(i)(1)(2) §483.60(i)(1) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not proclude residents from consuming foods not proceed by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff intrerview, the facility failed to clean and maintain kitchen equipment, clean meal carts, clean pots and pans appropriately, use dish sanitizer at manufacture recommended levels, maintain dishwasher temperatures and clean the kitchen floor. Jacob⊡s Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.		complaint investigation	on survey for Event #THU411			
The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview, the facility failed to clean and maintain kitchen equipment, clean meal carts, clean pots and pans appropriately, use dish sanitizer at manufacture recommended levels, maintain dishwasher temperatures and clean the kitchen foor. Jacob::s Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.				F 812		3/22/18
approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview, the facility failed to clean and maintain kitchen equipment, clean meal carts, clean pots and pans appropriately, use dish sanitizer at manufacture recommended levels, maintain dishwasher temperatures and clean the kitchen floor. The findings included: Jacob⊡s Creek Nursing and Periode to the sate met of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.			ty requirements.			
serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview, the facility failed to clean and maintain kitchen equipment, clean meal carts, clean pots and pans appropriately, use dish sanitizer at manufacture recommended levels, maintain dishwasher temperatures and clean the kitchen floor. The findings included: The findings included:		approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to co safe growing and foor (iii) This provision doe	ed satisfactory by federal, ies. bod items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility pompliance with applicable d-handling practices. es not preclude residents			
interview, the facility failed to clean and maintain kitchen equipment, clean meal carts, clean pots and pans appropriately, use dish sanitizer at manufacture recommended levels, maintain dishwasher temperatures and clean the kitchen floor.Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.		serve food in accorda standards for food se This REQUIREMENT by:	nce with professional rvice safety. is not met as evidenced			
		interview, the facility f kitchen equipment, cl and pans appropriate manufacture recomm dishwasher temperate floor.	failed to clean and maintain ean meal carts, clean pots ly, use dish sanitizer at ended levels, maintain ures and clean the kitchen		Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings factually correct and in order to maintai compliance with applicable rules and provisions of quality of care of residents The Plan of Correction is submitted as	is n s.
I I I I I I I I I I I I I I I I I I I					written allegation of compliance.	
	30RATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/29/2018 M APPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345050	B. WING				C / 22/2018
NAME OF PI	ROVIDER OR SUPPLIER	I		STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 +=	
				172	21 BALD HILL LOOP		
JACOB'S	CREEK NURSING AND I	REHABILITATION CENTER		MA	ADISON, 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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Continued From page	e 1	F 8	12			
	10:00 AM, revealed a hold box (holds food cooked) with a large a liquids and heavy bui the inside and outside During interview on 2 Dietary Aide (DA) #1 employee and was un expectation was for th kitchen or the equipment equipment was wiped DA#1 acknowledged equipment. She furth of the deep cleaning a During an interview o stated that the dietary gone about a week, b schedule in place for cleaning process. She of when the kitchen e cleaned last. The DM on a regular basis, th down things as much During an interview o #1 stated deep clean had not been done for	/19/18 at 10:15 AM, the stated she was new naware of what the ne cleaning process for the nent. DA #1 indicated the d down as they went along. the condition of the kitchen er stated she was unaware schedule. n 2/19/ at 10:33 AM, DA#2 / manager (DM) had been but there was no consistent several months on the e stated she was uncertain equipment had been deep d did not put out the schedule erefore, staff would wipe			Jacob S Creek Nursing and Rehabilitation Center S response to Statement of Deficiencies does not denote agreement with the Statemen Deficiencies nor does it constitute an admission that any deficiency is accu Further, JCNRC reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F812 Food Procurement, Store/Prepare/Serve-Sanitary The plan of correcting the specific deficiency The position of Jacob's Creek Nursing and Rehabilitation Center regarding t process that lead to this deficiency; t facility did not clean and maintain kito equipment, clean meal carts, clean pe and pans appropriately, use dish san at manufacture recommended levels, maintain dish washer temperatures a clean the kitchen floor. Facility supervisor/cooks did not ensure the dietary staff completed cleaning	t of rate. g he he hen ots itizer	
					assignments as required on 2/18/18 a 2/20/18. Facility supervisor/cooks did ensure that the 3 compartment sink h adequate dish sanitizer in place on	l not	
	An observation on 2/2	21/18 at 11:39 AM, revealed ad not been cleaned and the d un-cleaned.			2/19/18 and 2/21/18. Facility supervisor/cooks did not ensure dish machine and 3 compartment sink temperatures were maintained on 2/1		pet Page 2 of 1

Facility ID: 923026

If continuation sheet Page 2 of 14

ATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY
		345050	B. WING				C
	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	0.	2/22/2018
					21 BALD HILL LOOP		
JACOB'S	CREEK NURSING AND F	REHABILITATION 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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 812	Continued From page	e 2	F 8 ²	12			
_			10		and 2/21/18.		
	b. An observation of t	the four burner stove and					
		1:39 AM, revealed a large			Jacob's Creek Nursing and Rehabilita	ition	
	amount of burnt food	particles, brown/black			Center's plan for correcting the deficie	ency	
		ldup of grease inside each			is to ensure that kitchen equipment is		
		crusted inside the oven. The			maintained and clean, meal carts are		
		and liquid dripping on the			clean, pots and pans are clean, kitche		
	fronts and sides.				floor is clean, dish sanitizer is present		
	D · · · · · ·				manufacturers recommended levels a	ind	
	-	n 2/19/ at 10:33 AM, DA#2			dish machine temperatures/3		
		y manager had been gone			compartment sink temperatures are maintained to ensure food is stored,		
	about a week, but the	several months on the			prepared, distributed and served in		
		e stated she was uncertain			accordance with professional standar	de	
	• •	equipment had been deep			for food service safety.	45	
		did not put out the schedule					
		erefore, staff would wipe			Facility is in process of hiring Dietary		
	down things as much	-			Manager for the Dietary Department.		
		oven on 2/21/18 at 11:39			The procedure for implementing the		
		tove had not been cleaned.			acceptable plan of correction for the		
	-	n 2/19/18 at 10:45 AM, Cook			specific deficiency cited		
		ing of the kitchen equipment					
		or several months. In addition			On 2/21/18, dietary staff and		
		cleaning schedule since Staff basically wipe things			administrative staff including Administrator, DON, Housekeeping		
	-	ong. She indicted she was			Supervisor, Administrative CNA, MDS	:	
	unaware of who was	-			Nurse and Administrative Assistant	•	
	cleaning, stoves, ove	• •			cleaned kitchen equipment, meal cart	S.	
					pots and pans and kitchen floor. On	,	
	c. An observation of t	he six compartment steam			2/21/18 Administrative Assistant 2		
		able revealed dried foods			replaced dish sanitizer. On 2/21/18, th	ne	
	•	matter encrusted in the six			Administrator checked the dish maching		
		mpartments were left over			for appropriate temperature to ensure		
		ucts in standing water. The			appropriate temperature achieved and	b	
		ment had a large amount of			maintained. Temperature was 160		
		n and black matter on the			degrees during the wash cycle and 18	30	
	walls of the compartn	nent and floating in the		1	degrees during the rinse cycle.		

Facility ID: 923026

If continuation sheet Page 3 of 14

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		LETED
						2
		345050	B. WING		02/2	22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
IACOBIS		REHABILITATION CENTER		1721 BALD HILL LOOP		
IACOD C				MADISON, NC 27025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 812	Continued From pag	е 3	F 81	12		
1 012		ter on the surface of the	FOI	On 3/16/18, the Adminis	trator initiated	
		where clean dishes were		education of all dietary s		
-		le had dried foods, crumbs		assigned daily cleaning		
		rfaces and underneath		deep cleaning assignme		
	-	ods and clean dishes were		monitoring of dish mach		
	stored.			sanitizer is present and		
				appropriately by utilizing		
	During interview on 2	2/19/18 at 10:15 AM, the		monitoring sink tempera	-	
	Dietary Aide (DA) #1			compartment sink. All d		
	employee and was u			educated by 3/22/18. A		
		he cleaning process for the		dietary aids or cooks will		
		nent. DA #1 indicated the		assigned daily cleaning		
	equipment was wipe	d down as they went along.		deep cleaning assignme	nts, temperature	
	DA#1 acknowledged	the condition of the kitchen		monitoring of dish mach	ine, ensuring dish	
	equipment. She furth	er stated she was unaware		sanitizer is present and	dispensed	
	of the deep cleaning	schedule.		appropriately by utilizing		
				monitoring sink tempera		
		on 2/19/ at 10:33 AM, DA#2		compartment sink in orie	entation.	
		y manager had been gone				
		ere was no consistent		On 3/16/18, the Adminis		
		several months on the		Corporate Dietary Const	-	
		e stated she was uncertain		cleaning and deep clean		
		equipment had been deep		dietary staff for immedia	te	
		I did not put out the schedule		implementation.		
		nerefore, staff would wipe				
	down things as much	as possible.		On 3/16/18, the Adminis	-	
		- 0/40/40 -+ 40:45 ANA O		temperature logs for the		
	-	on 2/19/18 at 10:45 AM, Cook		and the 3 compartment s	-	
	-	ing of the kitchen equipment or several months. In addition		staff to consistently reco of the dish machine and	-	
				compartment sink for im		
		l cleaning schedule since f basically wipe things down		implementation.	meulale	
	-	She indicted she was		On 3/16/18 Administrato	r and Corporate	
		responsible for deep		Dietary Consultant provi		
	cleaning, stoves, ove			log for dietary staff to red		
	-	the coffee and tea machine		being present and PH st		
		and particles hanging from		immediate implementation		
		e drain. The tea canisters				
		liquids on the nozzle and		The monitoring procedu	a to oppure that	

Facility ID: 923026

If continuation sheet Page 4 of 14

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY MPLETED
		345050	B. WING			C)2/22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
JACOB'S	CREEK NURSING AND F	REHABILITATION CENTER		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 812	Continued From page	e 4	F 812			
	outside of the caniste During an interview o Dietary Aide (DA) #1 employee and was ur expectation was for th kitchen or the equipment was wiped DA#1 acknowledged equipment. She furthe of the deep cleaning s During an interview o stated that the dietary about a week, but the schedule in place for cleaning process. She of when the kitchen e cleaned last. The DM	r. n 2/19/18 at 10:15 AM, the stated she was a new naware of what the ne cleaning process for the ent. DA #1 indicated the d down as they went along. the condition of the kitchen er stated she was unaware schedule. n 2/19/ at 10:33 AM, DA#2 wmanager had been gone ere was no consistent several months on the e stated she was uncertain quipment had been deep did not put out the schedule erefore, staff would wipe		the plan of correction is eff specific deficiency cited rea and/or in compliance with the requirements The Administrator, DON, A Corporate Consultant, Statinurse, Infection Control Nu Manager (once hired) and/ will utilize audit tools to ens compliance with cleaning real dish sanitizer presence and manufacturers recommend temperature monitoring of machine and 3 the compare These audit tools will be contine times a week for 4 weeks, weeks, monthly for 4 monter The title of the person resp implementing the acceptate	Mains corrected the regulatory ADON, ff Facilitator, QA Irse, Dietary for MDS nurse sure continued equirements, d at ded levels, and the dish tment sink. completed daily 5 weekly for 4 hs.	
	#1 stated deep cleaning had not been done for there had not been a before the holidays. So down as they went all unaware of who was cleaning, stoves, ove During an interview of #2 stated the expectation in and clean the kitch	ns, carts etc. n 2/21/18 at 3:00 PM, Cook ation was for all staff to pitch en prior to the end of the redged there was no kitchen ailable.		correction In the absence of a dietary Administrator is responsibl implementation of the acce correction.	e for	

If continuation sheet Page 5 of 14

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	: 03/29/2018 APPROVED . 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		INSTRUCTION		(X3) DATE : COMPI	SURVEY _ETED
		345050	B. WING				(02/2	<i>;</i> 22/2018
NAME OF PF	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP COE	DE	•===	
IACOB'S		REHABILITATION CENTER		1721	BALD HILL LOOP			
UACOB C				MAD	DISON, 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 OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 812	Continued From page	e 5	F 8	12				
	encrusted in the grov carts. During interview on 2 Dietary Aide (DA) #1 employee and was un expectation was for the kitchen or the equipme equipment was wiped DA#1 acknowledged equipment. She furth of the deep cleaning and During an interview of stated that the dietary about a week, but the schedule in place for cleaning process. She of when the kitchen e cleaned last. The DM on a regular basis, th down things as much	haware of what the he cleaning process for the hent. DA #1 indicated the d down as they went along. the condition of the kitchen er stated she was unaware schedule. n 2/19/ at 10:33 AM, DA#2 y manager had been gone ere was no consistent several months on the e stated she was uncertain equipment had been deep d did not put out the schedule erefore, staff would wipe as possible. n 2/19/18 at 10:45 AM, Cook						
	had not been done for there had not been a before the holidays. S down as they went al unaware of who was cleaning, stoves, ove							
	#2 stated the expecta in and clean the kitch	ation was for all staff to pitch en prior to the end of the rledged there was no kitchen						
	3. An observation of	the dry storage rack on			UD: 923026			

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		ID HUMAN SERVICES MEDICAID SERVICES					PRINTED: (FORM A OMB NO. ()	PPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		NSTRUCTION		(X3) DATE SU COMPLET	RVEY
		345050	B. WING _				C 02/22 /	2018
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CO BALD HILL LOOP	DE		
JACOB'S	CREEK NURSING AND I	REHABILITATION CENTER			ISON, 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 OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE		(X5) COMPLETION DATE
F 812	2/19/18 at 10:10 AM, large silver and 16 m stacked with dried for and a heavy grease b surfaces. During an interview o stated that the dietary about a week, but the schedule in place for cleaning process. Sh of when the kitchen e cleaned last. The DM on a regular basis, th down things as much During an interview o #1 stated deep clean had not been done for there had not been a before holidays. Staff as they went along. S unaware of who was cleaning, stoves, ove An observation on 2/2 the 9 silver trays had buildup, 6 medium pa remain greasy on the During an interview o #2 stated he was res pots/pans and runnin checking the dish ma Cook #2 indicated the was pressed five time solution went into the response when asked	revealed 9 gray trays, 9 edium silver containers od particles inside/outside puildup on the outside an 2/19/ at 10:33 AM, DA#2 y manager had been gone ere was no consistent several months on the e stated she was uncertain equipment had been deep 1 did not put out the schedule erefore, staff would wipe as possible. In 2/19/18 at 10:45 AM, Cook ing of the kitchen equipment or several months. In addition cleaning schedule since f basically wipe things down She indicted she was responsible for deep ns, carts, floors etc. 21/18 at 11:39 AM, revealed large amounts of grease ans and 8 large silver pans of dry storage rack. In 2/21/18 at 3:00 PM, Cook ponsible for washing g the dish machine and chine temperatures at night. e disinfect solution button es to ensure the disinfect sink. There was no	F	312				

Facility ID: 923026

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345050	B. WING				C / 22/2018
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
JACOB'S	CREEK NURSING AND F	REHABILITATION CENTER			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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	of solution was not er 4a. An observation of that was used to was 2/19/18 at 10:10 AM, and a pans with a bot attached to the sink. b. An observation on revealed the 3 compa- solution in the sink an work. The temperatur sink at all. During an interview w 2/21/17 at 2:55 PM, s use the test strip, to te sanitize compartment compartment sink com manufacture recomm During an interview of #2 stated he was resp pots/pans, running the checking the dish mar Cook #2 indicated the was pressed five time solution went into the response when asked checking the sink gau of solution was not er 5. An observation of t 2/21/18 at 2:55 PM, re 155 and the rinse cyc a large volume of dete outside dripping on the	npty. the 3 compartment sink in the pots and pans on revealed staff washing pots the of empty sanitizer 2/21/18 at 2:55 PM, intment sink had no disinfect id the PH strips did not e gauge did not work on the with the Dietary Consultant on he stated that staff should est and make sure that the of the three (3) intained sanitizer that met endations in 2/21/18 at 3:00 PM, Cook consible for washing e dish machine and chine temperatures at night. e disinfect solution button is to ensure the disinfect sink. There was no a the expectation for ige and ensuring the bottle inpty. he dishwashing machine on evealed the wash cycle was le was 175. The inside had ergent buildup and on the e floor.	F	812			
		achine temperature log had					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	: 03/29/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345050	B. WING				02/2	22/2018
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP COD	E		
JACOB'S	CREEK NURSING AND F	REHABILITATION CENTER			BALD HILL LOOP DISON, NC 27025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 812	 2/19/18-2/21/18 and 0 2/21/18. During an interview o stated the only respon- make sure the dish m temperature and doct log. The DA#3 did no the temperature of the documented for two of During an interview o #2 stated he was resp pots/pans, running the checking the dish ma 6. An observation on 2/21/18 at 11:39 AM a kitchen floor near the dishwashing area had en heavy black grease b large amounts of old underneath the sink, embedded grease, bl dishwasher area had black/brown matter for paper products under machine. During an interview o stated that the dietary about a week, but the schedule in place for cleaning process. Sho of when the kitchen e cleaned last. The DM 	on 1st shift 2/20/18 to n 2/21/18 at 2:55 PM, DA#3 nsibility for the DA was to nachine was at proper umented on the temperature t respond when asked why e machine had not been days. n 2/21/18 at 3:00 PM, Cook ponsible for washing e dish machine and chine temperatures at night. 2/19/18 at 10:00 AM and and 2:55 PM, revealed the stove, sink area and d a large volume of trash The floor surface in front of mbedded food, dirt and wildup. The sink area had food, old paper products the floor surfaces had ack/brown matter. The large amount of embedded bod, standing water and old meath and in front of n 2/19/ at 10:33 AM, DA#2 y manager had been gone	F	312				

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FICIENCIES RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	
		A. BUILDING			E SURVEY IPLETED
	345050	B. WING		02	C 2/22/2018
ER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COE		
EK NURSING AND	REHABILITATION CENTER	17	721 BALD HILL LOOP		
		M	ADISON, NC 27025		
(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
ntinued From page	e 9	F 812			
vn things as much	as possible.				
During an interview on 2/20/18 at 2:30 PM, the Administrator indicated she was in the process of hiring a dietary manager and assistant. She acknowledged the kitchen needed attention.					
ted any staff could de/out. Staff that	on 2/21/18 at 2:55 PM, DA#3 I clean the dish machine had free time was ing the dish machine and				
stated the expecta and clean the kitch	on 2/21/18 at 3:00 PM, Cook ation was for all staff to pitch nen prior to the end of the vledged there was no kitchen ailable.				
tary Consultant st nager was respon- erations in the kitc king properly. The sure all aspects of intained in accord its. The Dietary Co		F 867			3/22/18
33.75(g)(2) The qu	uality assessment and e must:				
33.75(g)(2) The quice committee	g) Quality assessment and assurance. g)(2) The quality assessment and ce committee must:	g)(2) The quality assessment and ce committee must:	g)(2) The quality assessment and ce committee must:	g)(2) The quality assessment and

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		ID HUMAN SERVICES			PRINTED: 03/29/201 FORM APPROVEI OMB NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345050	B. WING		02/22/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•
IACOBIS		REHABILITATION CENTER	1	1721 BALD HILL LOOP	
UACOD 0			r	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 OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 867	Continued From page	e 10	F 867		
	by:				
		ns, policy review and staff		Jacob S Creek Nursing and	
		' 's Quality Assessment and Committee failed to maintain		Rehabilitation Center acknowledges receipt of the Statement of Deficience	ies
	implemented procedu			and proposes this Plan of Correction	
	interventions the com			the extent that the summary of findin	
	-	cation survey of 02/23/17.		factually correct and in order to main	
		ciency that was originally		compliance with applicable rules and	
	-	017 and was subsequently at recertification survey of		provisions of quality of care of reside The Plan of correction is submitted a	
		ed deficiency was in the		written allegation of compliance.	5 d
		The continued failure of the			
	-	eral surveys of record show		Jacob⊡s Creek Nursing and	
		y ' s inability to sustain an		Rehabilitation Center s response to	this
	effective Quality Assu	irance (QA) Program.		Statement of Deficiencies does not	
	Findings included:			denote agreement with the Statemer Deficiencies nor does it constitute an	
	Finalitys included.			admission that any deficiency is accu	
	This tag is cross refe	renced to F812 Food Safety		Further, JCNRC reserves the right to	
		d on observations, policy		refute any of the deficiencies on this	
		rviews, the facility failed to		Statement of Deficiencies through	
		tchen equipment, clean		Informal Dispute Resolution, formal	
		s and pans appropriately,		appeal procedure and/or any other	
		nanufacturer-recommended vasher temperatures, and		administrative or legal proceeding.	
	clean the kitchen floo	-		F867 QAPI/QAA Improvement Activit	ties
		ecertification survey of		The plan of correcting the specific	
	foods stored in the dr	id failed to properly label y storage room, walk-in		deficiency	
	refrigerator, walk-in fr room refrigerator.	eezer, and one nourishment		The position of Jacob's Creek Nursin and Rehabilitation Center regarding t	the
	la sa inten i soo	100140 at 4:07 a 11		process that lead to this deficiency –	the
		/22/18 at 4:07 p.m., the led that the facility had a		facility's Quality Assessment and Assurance Committee did not mainta	ain
	Quality Assurance an	-		implemented procedures and monito	
		program in place. She		interventions the committee put in to	
		& A Committee consisted at		following the recertification survey of	-
		uals in the following roles:		2/23/17.	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/29/20 FORM APPROV OMB NO. 0938-03	/ED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345050	B. WING		C 02/22/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		_
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 PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO	ON
F 867	Administrator, Medica Coordinator, Director Pharmacist, Medical Manager, and House indicated her awaren oversight and stated replacements for rece She shared her expe properly clean and sa areas as well as the o dinnerware used to s stated that individuals	al Director, QAPI of Nursing, Social Worker, Records designee, Dietary keeping Supervisor. She ess of lapses in kitchen she was working to hire staff ently terminated employees. ctation that kitchen staff anitize all food preparation cooking equipment and erve residents. She further s in kitchen management itor staff members daily to	F 86	 Jacob's Creek Nursing and Rehab Center's plan for correcting the dei is to ensure implemented procedu developed by the Quality Assessm Assurance Committee are maintai an ongoing basis to sustain an effe Quality Assurance Program. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 3/8/18 the facility QAA/QAPI Committee held a meeting to reviee purpose and function of the QAA/Q Committee and review ongoing compliance issues. The Administr DON, QA Nurse, Infection Control Staff Facilitator, Housekeeping Supervisor, will attend QAA/QAPI Committee meetings on an ongoin and will assign additional team me as appropriate. On 3/16/18 the corporate facility consultant educated the Administra related to the appropriate function the QAA/QAPI Committee and the purpose of the committee to include identifying issues and correcting re deficiencies related to F812 Food a Requirements. On 3/16/18 the Administrator bega educating the department heads re to the appropriate functioning of the QAA/QAPI Committee and the pur the committee to include identifying 	ficiency res hent and ned on ective he he he withe QAPI ator, Nurse, g basis embers ator ng of fle epeat Safety in elated e rpose of	

Event ID: THU411

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 03/29/2018 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345050	B. WING			C 02/22/2018		
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	122/2010	
JACOB'S CREEK NURSING AND REHABILITATION CENTER					721 BALD HILL LOOP IADISON, NC 27025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 867	Continued From page	÷ 12	F	867	and correcting repeat deficiencies reto F812 Food Safety Requirements. As of 3/16/18 after the facility consule education, the facility QAA/QAPI committee will begin identifying othe areas of quality concern through the review process, for example: review environmental round tools, review of maintenance work orders, review of resident rounds tools, review of resident concern logs, review of resident concern logs, review of resident concern logs, review of pharmacy reports, review of Point Click Care (Electronic Medical Record), review dietary consultant recommendations review of facility consultant recommendations review of facility consultant recommendations. Even when plan of Correction monitoring is completed QAA/QAPI committee will routinely to back on precited deficiencies to ensuccontinued compliance. The facility QAA/QAPI Committee will quarterly to identify issues related to quality assessment and assurance activities and develop/implement appropriate plans of action for identific concerns. Corrective action has been taken for identified concerns related to F812 F Safety Requirements.	tant r QA of dent of and of ook ure ill ne tmeet fied the food that		
	7(02-99) Previous Versions Obs	olete Event ID: THU	411				et Page 13 of 14	

Event ID: THU411

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/29/2018 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROV		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY PLETED	
		345050	B. WING				C 02/22/2018	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		17	IREET ADDRESS, CITY, STATE, ZIP CODE 21 BALD HILL LOOP ADISON, 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 867	Continued From page	e 13	F	867	 and or in compliance with the regulate requirements The facility QAA/QAPI Committee will meet at a minimum of monthly with oversight by the Administrator. The Executive QAA/QAPI Committee meeting including the Medical Director meet quarterly and review quarterly compiled QAA/QAPI report information review trends, and review corrective actions taken including dates of completion. The Executive QAA/QAPI Committee will validate the facility's progress in correction of deficient praoir identify concerns. The Administrate will be responsible for ensuring committee training or other interventions. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementation of the acceptable plan correction. 	r will n, Pl ctice or hittee ler		

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