PRINTED: 04/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345050	B. WING		C 03/14/2018
	ROVIDER OR SUPPLIER CREEK NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025	1 00/14/2010
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 000	_	ntered the facility on 3/9/18 to	F 000		
	identified immediate exited the facility on obtained additional i telephone. Due to in ice, the survey team facility on 3/12/18 ar	•			
F 580 SS=D	Notify of Changes (I CFR(s): 483.10(g)(14) Notif (i) A facility must immore consult with the resistent with his consistent wit	rication of Changes. mediately inform the resident; dent's physician; and notify, or her authority, the resident then there is- diving the resident which has the potential for requiring on; nge in the resident's physical, ocial status (that is, a th, mental, or psychosocial preatening conditions or s); reatment significantly (that is, we an existing form of overse consequences, or to orm of treatment); or onsfer or discharge the	F 58		4/6/18
ADODATODY		R/SLIPPLIER REPRESENTATIVE'S SIGNATUR	DE	TITLE	(X6) DATE

Electronically Signed 04/05/2018

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345050	B. WING _			C 03/14/2018
	PROVIDER OR SUPPLIER CREEK NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025		00/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
F 580	(ii) When making not (14)(i) of this section all pertinent informat is available and prove physician. (iii) The facility must resident and the resist when there is-(A) A change in room as specified in §483. (B) A change in reside the section (iv) The facility must update the address (phone number of the representative(s). §483.10(g)(15) Admission to a computation of the section (iv) The facility must update the address (phone number of the representative(s). §483.10(g)(15) Admission to a computation of a computation of the section of another resident's reviewed for a very section of another resident's reviewed for section all personal provention of another resident's reviewed for section and the section of the section of the section of another resident's reviewed for section and the resident's reviewed for the section of the section	ification under paragraph (g), the facility must ensure that ion specified in §483.15(c)(2) ided upon request to the also promptly notify the dent representative, if any, nor roommate assignment 10(e)(6); or lent rights under Federal or ons as specified in paragraph in. Trecord and periodically mailing and email) and resident Toosite distinct part. A facility istinct part (as defined in e in its admission agreement atton, including the various see the composite distinct fy the policies that apply to be its different locations T is not met as evidenced view, staff and resident iews the facility failed to presentatives and physicians f a previous occurrence of ack of intervention for the roccurrence for 2 of 5 for notification of physical sident altercations (Resident	F5	Jacob's Creek acknowledges rethe Statement of Deficiencies a proposes this Plan of Correction extent that the summary of find factually correct and in order to compliance with applicable rule provisions of quality of care of recompliance The Plan of Correction is submaritten allegation of compliance	nnd nn to the ings is maintain es and residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345050	B. WING _		0.	C 3/14/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	71-72010	
				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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 580	Continued From pag	e 2	F 5				
	Findings included: 1. Record review revadmitted to the facilit dementia, anxiety disaccident, and depresdata set (MDS) asserevealed Resident #2 impaired requiring exmobility, range of moextremities, and depondersing unit. Record review of a 2 for second shift (3:00 by Nurse #2 indicate received from Nurse 3:00 PM) that Reside in an altercation. Nurse #2 was interview Nurse #3 on 3/2/18 at there was an altercation and Resident #1. Nu know what happened occurred. Nurse #2 in Resident #2 at the besident #2 at the besident #2 at the besident #2. Nurse #4 document this bruise on her shift. Nurse #3 assumption all the regarding the altercation.	ealed Resident #2 was y on 3/8/16 with diagnoses of sorder, cerebrovascular ision. The quarterly minimum issment dated 12/27/17 was severely cognitively itensive assistance with bed ition impairment of lower endent for locomotion on the impairment was #3 on first shift (7:00 AM to ent #2 and Resident #1 were ended on 3/9/18 at 4:40 PM. The received report from the change of shift that it in between Resident #2 are #2 indicated she did not in the altercation or when it indicated she went to assess enginning of her 3:00 PM to 12/18. Nurse #2 indicated she ise on the bridge of the nose we above the nose on #2 indicated she made the quired documentation tion and the assessment had		Jacob's Creek response to this of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constituted admission that any deficiency is Further, Jacob's Creek reserves to refute any of the deficiencies Statement of Deficiencies through Informal Dispute Resolution, for appeal procedure and/or any of administrative or legal proceeding. F580 Notify of Changes (Injury/Decline/Room, etc.) The plan of correcting the special deficiency. The position of Jacob's Creek Nand Rehabilitation Center regard process that lead to this deficient facility did not notify the resident representatives and physicians manner of a previous occurrence abuse resulting in a lack of interthe prevention of another occurrence of 5 resident's reviewed for notify physical abuse/resident to residulatercations (Resident #1 and R#2). Facility did not ensure that #1's and Resident #2's resident representatives and physicians notified on 3/2/2018. Jacob's Creek Nursing and Reficenter's plan for correcting the	of te an accurate. s the right on this gh mal her ng. fic fic fursing ding the ncy; the t in a timely e of vention for rence for 2 fication of ent esident Resident Resident were		
	been already comple AM to 3:00 PM) on 3	ted on the 1rst shift (7:00 /2/18.		is to ensure that the facility notifing resident representatives and phatimely manner of changes			

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			1	C (4.4/2048
NAME OF D	ROVIDER OR SUPPLIER	04000		07	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	/14/2018
NAME OF FI	NOVIDER OR SUFFLIER						
JACOB'S	CREEK NURSING AN	D REHABILITATION CENTER			721 BALD HILL LOOP		
				М	IADISON, NC 27025		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From pa	age 3	F 5	580			
	· ·	viewed on 3/9/18 at 3:52 PM.			(Injury/Decline/Room, etc.) to include		
		d she did give report to Nurse			occurrences of abuse.		
		er 7:00 AM to 3:00 PM shift on			occurrences of abase.		
		n altercation that had occurred			The procedure for implementing the		
		#2 and Resident #1. Nurse #3			acceptable plan of correction for the		
		on occurred between 9:00 AM			specific deficiency cited		
		rse #3 indicated when she			specific deficiency cited		
		t #2 there was no bruising or			On 3/10/2018, MDS-RN (Minimum Dat	а	
		ed like Resident #1 hit			Set-Registered Nurse) reviewed 100%		
		nose. Nurse #3 stated, "I did			progress notes from 3/2/2018 through		
		that time but thought I would			3/10/2018 to identify any changes		
		fter I finished my medication			(Injury/Decline/Room, etc.) to include		
		off to the oncoming nurse at			occurrences of abuse to ensure		
	·	to [Nurse #2]." Nurse #3			notification of resident representatives		
		ot notify anybody of the			and physicians in a timely manner.		
		n Resident #2 and Resident #1			, ,		
	other than Nurse #	2 on 3/1/18. Nurse #3			On 3/10/2018, Administrator reviewed		
	indicated she did n	ot fill out a progress note or an			100% incident reports from 2/28/2018		
	incident report on 3	3/2/18. Nurse #3 indicated she			through 3/10/2018 to ensure notificatio	n of	
	could not recall the	e exact day the altercation			resident representatives and physician	s in	
	between Resident	#2 and Resident #1 happened,			a timely manner. The audits resulted i	n	
	she thought it was	on a Wednesday.			no negative findings.		
		for Resident #2 dated 2/28/18			On 3/10/2018, DON (Director of Nursin	ıg)	
		cription of the incident that			initiated education on all nursing staff		
		ent observed in hallway			members on expectations of	_	
		esident. Male resident heard			documentation to include notification o		
		ny room." This resident yelled			resident representatives and physician	s in	
		oot him." Male resident hit this			a timely manner of changes		
		e/nose with his hand. Male			(Injury/Decline/Room, etc.) to include		
	•	s resident was in his room.			occurrences of abuse. All nursing staf		
		dents were observed in the			members were educated prior to worki	ng	
	•	resident's room at time of			their next assigned shift by 3/15/2018.		
		ocumentation in the incident			Any newly hired nursing staff members	I.	
		/17 indicated the physician was			will be educated on expectations of	c	
		lent on 3/5/18 at 1:47 PM and			documentation to include notification o		
		rty was notified on 3/5/18 at			resident representatives and physician	s in	
	1:47 PM.				a timely manner of changes		
					(Injury/Decline/Room, etc.) to include		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345050	B. WING _				C 14/2018
NAME OF PR	ROVIDER OR SUPPLIER		1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	14/2010
				17	21 BALD HILL LOOP		
JACOB'S	CREEK NURSING AND F	REHABILITATION CENTER			ADISON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	· 4	F 5	80			
	Review of the medica not reveal any docum	I record of Resident #2 did entation regarding an			occurrences of abuse in orientation.		
	altercation between R on 3/2/18 or 2/28/18.	tesident #1 and Resident #2			The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correction.	nat	
	#2 dated 3/3/18 state	nursing notes for Resident d, "Resident was sitting at dining room when another			and/or in compliance with the regulator requirements	у	
	CNA (certified nursing resident hitting this re Residents were separ contacted at 1901 (7:Representative) [Nam (7:10 PM) who made	01 PM). RR (Resident ne] was contact at 1910 a visit to the facility and ding. Deputy and detective			The ADON (Assistant Director of Nursing), MDS-RN and Restorative Nu will utilize audit tool to ensure continue compliance with notification of resident representatives and physicians in a tim manner of changes (Injury/Decline/Roc etc.) to include occurrences of abuse. These audit tools will be completed dai times a week for 4 weeks, weekly for 4	d ely om, ly 5	
	Nurse aide (NA) #7 w 12:20 PM. NA #7 indinurses station on 3/3/	ras interviewed on 3/10/18 at cated he was working at the 1/18 when he heard Resident rguing. NA #7 indicated he			weeks, monthly for 4 months. The title of the person responsible for implementing the acceptable plan of correction		
	indicated he observed reclining chair in a co- her in his wheel chair #1 had Resident #2 " #7 indicated he obser hitting Resident #2 wi	d that Resident #2 was in a rner with Resident #1 facing . NA #7 indicated Resident binned against the wall." NA rved Resident #1 repeatedly th his fist in the her face. NA iately separated Resident			The Administrator is responsible for the implementation of the acceptable plan correction.		
	3/12/18 at 10:32 AM. recall being notified of Resident #2 was invo 3/3/18. He stated he of	sident #2 was interviewed on He indicated he did not f an altercation for which Ived in the week prior to did not recall being notified cations between Resident					

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	ROVIDER OR SUPPLIER CREEK NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE 1721 BALD HILL LOOP MADISON, NC 27025	E, ZIP CODE	00/ 1 // 20 10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 580	Continued From pag	ge 5 entative of Resident #2 was	F	580			
	interviewed on 3/9/1 nursing supervisor of him of an altercation was struck by Resid informed by the nurs happened before. His knowledge of a previous representative indicated about the continued facility. The facility DON was 4:00 PM. She stated reporting, notification documentation of alternations.	8 at 11:40 AM. He stated a alled him on 3/3/18 to notify during which Resident #2 ent #1. He stated he was sing supervisor that this had e stated he had no ious incident. The resident ated he was then concerned safety of Resident #2 at the sinterviewed on 3/9/18 at I her expectations for no family, and ercations between residents					
	facility. She said the notify either the DON resident's family and altercations. The facility Administ 3/10/18 at 8:36 AM. were for any change behaviors and altercations are to be stated that if she had physical altercation,	ses during orientation to the nurses were expected to N or the Administrator, the I the physician of any resident rator was interviewed on She stated her expectations is in condition, to include ations, the family and the enotified. The Administrator dibeen notified of a previous prior to 3/3/18, between					
	Resident #1 on one possibly preventing on 3/3/18. 2. Resident #1 was a diagnoses of schizo Alzheimer's disease	sident #1, she would have put to one monitoring sooner an incident from happening admitted on 9/9/09 with ohrenia, dementia, and . The quarterly MDS dated sident #1 was moderately					

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 _			03/1	; 4/2018
	ROVIDER OR SUPPLIER	ID REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1721 BALD HILL LOOP MADISON, NC 27025) ODE	03/1	14/2010
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIAT		(X5) COMPLETION DATE
F 580	Record review of a for second (3:00 F Nurse #2 indicated from Nurse #3 on that Resident #2 a altercation. Nurse #2 was inte Nurse #2 indicated Nurse #3 on 3/2/1 there was an alter and Resident #1. I know what happer occurred. Nurse # Resident #2 at the 11:00 PM shift on observed a fresh that and a small red brown and a small re	ed with physical behaviors 1 to 3 sment period. a 24 hour report dated 3/2/18 M to 11:00 PM) completed by d a nursing report was received first shift (7:00 AM to 3:00 PM) and Resident #1 were in an a rviewed on 3/9/18 at 4:40 PM. d she received report from 8 at the change of shift that cation between Resident #2 Nurse #2 indicated she did not need in the altercation or when it 2 indicated she went to assess a beginning of her 3:00 PM to 3/2/18. Nurse #2 indicated she oruise on the bridge of the nose uise above the nose on e #2 indicated she made the required documentation recation and the assessment had pleted on the 1rst shift (7:00	F 5				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	· '	COMPLETED		
		345050	B. WING _			C 03/14/2018	
	ROVIDER OR SUPPLIER CREEK NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025		03/14/2010	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 580	later write a note after pass. I did report it of the end of the shift to indicated she did not altercation between I other than Nurse #2 indicated she did not incident report on 3/2 could not recall the ebetween Resident #2 she thought it was or An incident report for had a witness statem "Resident was in the with another resident them arguing, he sai yelled, someone sho [Resident #1] hit [Refist. Nurse ran over to them. Nurse told [Reanyone. Nurse asked her. He said she was was not. They both yelloorway. No injuries on the 2/28/18 incided physician was notifier responsible party was review of the medicanot reveal any documal tercation between I on 3/2/18 or 2/28/18. Record review of the #1 dated 3/3/18 states self into dining room	at time but thought I would for I finished my medication for to the oncoming nurse at a [Nurse #2]." Nurse #3 notify anybody of the Resident #2 and Resident #1 on 3/1/18. Nurse #3 fill out a progress note or an all of the exact day the altercation and Resident #1 happened, in a Wednesday. The Resident #1 dated 2/28/18 then the from Nurse #3, hallway and verbally arguing and [Resident #1]. Nurse heard and the continuous many separated them. Separated sident #2] in the nose with the separated them. Separated sident #1] that you do not hit all what was wrong that he hit is in my room. Clearly, she were in the hallway, near his noted." The documentation and report indicated the don 3/5/18 and the senotified on 3/5/18. The record of Resident #1 did mentation regarding an Resident #1 and Resident #2	F 5	80			

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		١	C 3/14/2018
	ROVIDER OR SUPPLIER CREEK NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025		3/14/2010
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	punching resident in Residents [were] sept contacted. [Resident was contacted. 1 on detective where cont Room change to 200 Nurse aide (NA) #7 v 12:20 PM. NA #7 ind nurses station on 3/3 #2 and Resident #1 aimmediately went to indicated he observe reclining chair in a coher in his wheel chair #1 had Resident #2 v #7 indicated he observe in his wheel chair #1 had Resident #2 v #7 indicated he immed #1 and Resident #2. The physician for Re 3/12/18 at 10:32 AM recall being notified of Resident #1 was involved.	pserved resident to be the face with a fist. parated. Administer was Representative] case worker 1 put in place. Deputy and acted to come to facility. I hall." I was interviewed on 3/10/18 at icated he was working at the larguing. NA #7 indicated he	F 58	·		
	interviewed on 3/12/ representative confir 3/5/18 of a previous #2 and Resident #1 t The resident represe	ntative for Resident #1 was 18 at 10:40 AM. The resident med she was notified on altercation between Resident hat happened prior to 3/3/18. Intative did not know the date ration between the two				

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				C
NAME OF DE	ROVIDER OR SUPPLIER	343030	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	03/	14/2018
		REHABILITATION CENTER		17	721 BALD HILL LOOP IADISON, NC 27025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580 F 600 SS=J	3/10/18 at 8:36 AM. S were that for any cha behaviors and alterca physician were to be stated that if she had physical altercation, p Resident #2 and Res Resident #1 on one to	ator was interviewed on the stated her expectations anges in condition, to include ations, the family and the notified. The Administrator been notified of a previous prior to 3/3/18, between adent #1, she would have put to one monitoring sooner in incident from happening		580			4/6/18
	_				Jacob's Creek 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 maintal compliance with applicable rules and provisions of quality of care of resident	in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7.1. 50.125.1110			С	
		345050	B. WING		o:	3/14/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				1721 BALD HILL LOOP			
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 10	F 60	0			
	right cheek and eye a Resident #1.	as a result of being hit by		The Plan of Correction is subm written allegation of compliance			
	Resident #2 in the fact Resident #2 being phe pain medication and a emergency room after jeopardy was remove facility provided an act of removal. The facility compliance at a scop D (not actual harm with minimal harm that is ensure monitoring an in-serviced. Findings included: Resident #2 was admitted with diagnoses of deriven and services of deriven and service	an assessment at an er the trauma. Immediate ed on 3/11/18 when the exceptable credible allegation ty will remain out of the end severity level position with potential for more than the immediate jeopardy) to ad all staff have been entitled to the facility on 3/8/16 mentia, anxiety disorder,		Jacob's Creek response to this of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constituted admission that any deficiency is Further, Jacob's Creek reserved to refute any of the deficiencies Statement of Deficiencies through Informal Dispute Resolution, for appeal procedure and/or any of administrative or legal proceeding F600 Free from Abuse and Negative The plan of correcting the specificiency.	e of of ute an a saccurate. s the right on this gh rmal ther ng.		
	cerebrovascular accident, and depression. The quarterly minimum data set (MDS) assessment dated 12/27/17 revealed Resident #2 was severely cognitively impaired requiring extensive assistance with bed mobility, range of motion impairment of lower extremities, and dependent for locomotion on the nursing unit. Resident #1 was admitted on 9/9/09 with diagnoses of schizophrenia, dementia, and Alzheimer's disease. The quarterly MDS dated 1/11/18 revealed Resident #1 was moderately cognitively impaired with physical behaviors 1 to 3 days of the assessment period. The documentation in the care plan last updated on 3/3/18 for Resident #1 revealed a focus area for the problematic manner in which the resident			and Rehabilitation Center regar process that lead to this deficie facility failed to protect a cogniti impaired resident (Resident #2) physical abuse inflicted by a co impaired resident (Resident #1) sampled residents reviewed for abuse. Facility did not ensure the protected a cognitively impaired (Resident #2) from physical abuse inflicted by a cognitively impaired (Resident #1) on 3/2/2018. Jacob's Creek Nursing and Ref Center's plan for correcting the is to ensure that the facility protection cognitively impaired residents for physical abuse inflicted by cognitical solutions.	ncy; the evely from gnitively for 1 of 4 physical that they deresident use ed resident deficiency ects		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		X2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345050	B. WING _			1	C 1 4/2018	
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	14/2010	
					721 BALD HILL LOOP			
JACOB'S	CREEK NURSING AND I	REHABILITATION CENTER			IADISON, NC 27025			
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F 600	Continued From page	e 11	F 6	00				
	staff, and verbal/phys	g skills, aggression, ed to cursing, hitting grabbing sical aggression toward other ne care plan was updated on			impaired residents to include Resident and Resident #2. The procedure for implementing the	#1		
	2/5/18 for one on one until his behavior sub visual checks to mon	e monitoring of Resident #1 sided and then 15 minute itor his behavior/needs. The			acceptable plan of correction for the specific deficiency cited			
		pdated on 3/3/18 with the none monitoring of the			On 3/8/18, the administrator facilitated quality improvement meeting with DON ADON, Social Worker, QI (Quality Improvement) Nurse, Infection Control	l,		
	records (MAR) dated	edication Administration 2/23/18 to 3/6/18 revealed ng monitored every 15			Nurse, Restorative Nurse, RN Supervis and Staff Facilitator to discuss: 1) what was being done to protect Resident #1	t		
	with the Quality Impro 3/10/18 at 10:44 AM	ve behavior. An interview ovement (QI) Nurse on revealed Resident #1 had			how to keep Resident #2 from having altercations with other residents, 3) the root cause of the resident to resident			
	an intervention added Resident #1 had a pro	sual checks since 2/5/18 as d to the care plan after evious physical altercation			altercation, 4) education of nurses. On 3/8/18, Social Worker #1 and Social			
	confirmed the facility	in the facility. The QI nurse nurses were performing 15 on 2/28/18 and 3/2/18.			Worker #2 initiated interviews with all a and oriented residents. The social workers asked three (3) questions: 1)	Do		
	had a witness statem				you feel safe at Jacob's Creek? 2) Has anyone, including residents, made you feel unsafe or threatened you? 3) If			
	with another resident them arguing, he said	hallway and verbally arguing . [Resident #1]. Nurse heard d, "Get out of my room." She			someone, including another resident, were to make you feel unsafe or threatened you do you know who to re			
	[Resident #1] hit [Resident #1	ot him. Then nurse saw sident #2] in the nose with o separate them. Separated sident #1] that you do not hit			it to? On 3/9/18 Social Worker #1 and Social Worker #2 completed the interviews. The interviews resulted in r negative findings.			
	her. He said she was was not. They both w doorway. No injuries on the incident report	I what was wrong that he hit in my room. Clearly, she were in the hallway, near his noted." The documentation to f the immediate action esidents were immediately			On 3/10/18, at approximately 1:30pm, administrator instructed the DON to continue Resident #2 on 1:1 supervisio 24 hours per day, until the interdisciplir (IDT) behavior team determines 1:1	on,		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		E SURVEY IPLETED
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JACOB'S	CREEK NURSING AN	ID REHABILITATION CENTER		1721 BALD HILL LOOP		
				MADISON, NC 27025		
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F 600	Continued From p	age 12	F 6	500		
F 600	redirected. Female assisted to dining (Resident #1) roor resident's (Reside residents from apprint with the residents from apprint with the reviewed. Recent implemented by PMD notified. RR (rootified." The incident report had a nursing destated, "Male resident gright with this reyelling "get out of back "someone should be resident in the factor resident in the factor resident reports the However, both resident resident resident with the revealed she filled Monday 3/5/18 for	e resident (Resident #2) was room, away from this resident's m. Stop sign in place in nt #1) doorway to help deter proaching resident's room. 15 cks continue in place to help naviors. Resident is currently for psych services. Medications medication changes sych during visit on 2/26/18. esident representative) It for Resident #2 dated 2/28/18 cription written by Nurse #3 that dent observed in hallway esident. Male resident heard my room" This resident yelled noot him." Male resident hit this e/nose with his hand. Male is resident was in his room. Sidents were observed in the resident's room at time of the progress notes for Resident for the events described on the eport. Documentation on the minute checks were being he nursing staff on 2/28/18. Nurse #3 on 3/10/18 at 3:52 PM out an incident report on events that occurred on confirmed she separated	F6	supervision is no longer necess IDT (Interdisciplinary Team) be team will review and discuss he behavior residents, to include and Resident #2. The IDT be will meet weekly for six (6) modetermine maintaining of applinterventions such as the need continued 1:1 supervision, 24 day. On 3/10/18, at approximately clinical teams of the ADON and (Certified Nursing Assistant) # and Restorative nurse, and the supervisor and CNA #3 complianted residents. The skin as findings were given to the DO cause analysis, completed 3/1 outcome of the skin assessment (but care Registry. All area during the skin assessment (but tears) had determinable caused On 3/10/18, the MDS-RN community to the Care Registry as a 24 hour remainstrator submitted to the Care Registry as a 24 hour remainstrator of 3/10/18. On 3/10/18 the administrator of 3/10/18. On 3/10/18 the administrator of 3/10/18.	ehavior high risk Resident #1 havior team onths to icable d for hour per 2:30pm, id CNA i2, QI nurse e RN leted a lon-alert and lassessment N for root 12/18. The lents was no licion to the las identified oruises, skin les. upleted a less notes The audit e Health port on	
	Resident #1 and # minute checks on	2 and continued with the 15 2/28/18.		incident/accident reports from through 3/10/18 to identify any incidents/accidents that would	/	

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JACOB'S	CREEK NURSING AND	REHABILITATION CENTER		M	IADISON, NC 27025		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 600	Continued From page	e 13	F	600			
	An interview was con	ducted with the facility			follow-up related to resident abuse. The	е	
	Administrator on 3/10	0/18 at 8:36 AM. The			audit revealed eight (8) incidents that the	ne	
	Administrator revealed	ed she was not aware of the			facility implemented appropriate		
		ere Resident #1 struck			interventions such as room changes,		
	Resident #2, until she	e was notified by Nurse #6			medication adjustments, and clinical		
		nistrator confirmed Resident			interventions.		
		one monitoring and was					
		Ilway on 3/3/18 to protect			On 3/10/18 the RVP (Regional Vice		
	Resident #2 and the				President) completed an education with		
	Administrator stated that if she had been notified of a previous physical altercation, prior to 3/3/18,				the administrator and DON regarding the	16	
		and Resident #1, she would			responsibility of the administrator and DON to complete 24 hour and 5 day		
		on one to one monitoring			reports to the Health Care Registry.		
	1	enting an incident from			reports to the ricaliti Gale Registry.		
	happening on 3/3/18	_			On 3/10/18 the RVP educated the		
	pp =g = = . = .				administrator and DON regarding the u	ise	
	An interview with the	Director of Nursing (DON)			of the Allegations of Resident to Reside		
		M revealed the QI Nurse			Abuse checklist. The training included		
	started interviews wit	h the staff and obtaining			directive for the administrator to educa		
	statements on 3/6/18	regarding the altercation			all the department heads (QI nurse, MI	os	
	between Resident #1	and Resident #2. The DON			nurse, administrator's assistant,		
		seen or heard the events			administrative assistant, social workers	; ,	
		\$\frac{1}{3}\$ in the incident report dated			medical records, accounts payable,		
	2/28/18.				accounts receivable, activities assistan		
					and housekeeping supervisor) on the u		
		QI nurse on 3/10/18 at			of the Allegations of Resident to Reside	ent	
		he reviewed and revised the			Abuse checklist.		
		2/28/18 on Wednesday, revealed the Administrator			On 3/10/18 the administrator initiated a	ın.	
		ursing signed off on the			education for all department heads	.11	
		2/28/17 on Thursday,			regarding the prevention and		
	3/8/18.	2,23,17 311 111d13ddy,			administrative oversight of abuse/resid	ent	
					to resident altercation. All department		
	Record review of a 2	4 hour report dated 3/2/18			heads were educated prior to their nex		
	for second shift (3:00 PM to 11:00 PM) completed				scheduled day to work by 3/12/18. Any		
	1	d a nursing report was			newly hired department heads on the		
		#3 on first shift (7:00 AM to			prevention and administrative oversigh	t of	
		ent #2 and Resident #1 were			abuse/resident to resident abuse		
	in an altercation.				altercation in orientation.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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JACOB'S	CREEK NURSING AND	REHABILITATION CENTER		M	ADISON, NC 27025		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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	Nurse #2 was intend	iewed on 3/9/18 at 4:40 PM.			On 3/10/18 the DON, ADON, QI nurse.		
		she received report from			and Infection Control Nurse began		
		at the change of shift that			educating all nursing staff members on		
		ition between Resident #2			documentation expectations with regar		
		urse #2 indicated she did not			to resident to resident altercations and		
		d in the altercation or when it			documentation. All nursing staff memb	ers	
		indicated she went to assess			were educated prior to working their ne		
		eginning of her 3:00 PM to			scheduled shift by 3/15/18. Any newly		
		2/18. Nurse #2 indicated she			hired nursing staff members will be		
	observed a fresh bru	uise on the bridge of the nose			educated on documentation expectation	ns	
	and a small red bruis	se above the nose on			in orientation.		
	Resident #2. Nurse	#2 indicted she did not					
	document this bruise	e because it did not happen			On 3/11/18, the administrator, DON,		
	on her shift. Nurse #	2 indicated she made the			ADON, QI nurse, MDS-RN, RN charge		
	assumption all the re	equired documentation			nurse, social worker, therapy manager	,	
		ation and the assessment had			weekend manager on duty, and/or		
		eted on the first shift (7:00 AM			corporate consultant educated all staff		
	-	8. Nurse #2 indicated that			members on how to supervise and		
	_	sident #1 every 15 minutes			monitor residents at high risk for		
		and was documented on the			abuse/resident to resident altercation.	All	
	MAR.				staff members were educated prior to		
	N #2 :	iourad an 2/0/40 ct 2:50 DM			working their next scheduled shift by		
		iewed on 3/9/18 at 3:52 PM.			3/15/18. Any newly hired staff membe	S	
		she did give report to Nurse			will be educated on documentation		
		7:00 AM to 3:00 PM shift on			expectations in orientation.		
		altercation that had occurred 2 and Resident #1. Nurse #3			On 3/11/18, the Administrator, DON,		
		n occurred between 9:00 AM			ADON, QI nurse, MDS-RN, Activity		
		e #3 indicated when she			Director and Social Worker began a		
		#2 there was no bruising or			weekly IDT behavior team meeting to		
		d like Resident #1 hit			identify and review residents through the	ne	
		ose. Nurse #3 stated, "I did			following criteria: 1) admission paperwo		
		nat time but thought I would			2) progress note review, 3) incident rep		
		er I finished my medication			review, 4) social work note review, 5) 2		
		off to the oncoming nurse at			hour report sheet review, 6) other		
	l ·	o [Nurse #2]." Nurse #3			pertinent medical information. The fac	lity	
		t notify anybody of the			will implement interventions to reduce	he	
		Resident #2 and Resident #1			risk of abuse incidents and to provide	ļ	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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JACOB'S	CREEK NURSING AND F	REHABILITATION CENTER			721 BALD HILL LOOP		
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	other than Nurse #2 of indicated she did not incident report on 3/2				focused supervision of high risk behavioral residents. On 3/11/18, the administrator, DON,		
	between Resident #2	and Resident #1 happened,			ADON, QI nurse, social worker, and/or		
	_	a Wednesday. Nurse #3			staff facilitator began educating newly hired staff during orientation regarding		
		ing of Resident #1 every 15 nd new interventions were			high risk behavior residents, what to		
	not implemented on 3				watch for, what to do, when to report, watch	vho	
					to report to, and what to document.		
		al records of Resident #2 and			On 0/44/40 the Anticities Discretes because		
	I .	eveal any documentation ion between Resident #1 and			On 3/11/18, the Activities Director begated developing activities based on	เท	
	Resident #2 on 3/2/18				recommendations from the IDT behavi	or	
	11001001111112 011 0727 11	-			team beginning in the 3/11/18 meeting	-	
	Record review of the	nursing notes for Resident			The Activities Director began asking		
	#2 dated 3/3/18 state	d, "Resident was sitting at			families for ideas to occupy high risk		
		dining room when another			residents (ideas such as: previous like:		
	1	ng self into the dining room.			previous occupation skills, hobbies, etc		
	1	g assistant) observed other			based on recommendations from the II		
	resident (Resident #1				meeting. The activity department will be	е	
	` <i>'</i>	ace with a fist. Residents ninister was contacted at			required to carry out the care planned activities for high risk behavior residen	to	
		(Resident Representative)			High risk behavior resident activities m		
	1	at 1910 (7:10 PM) who made			be facilitated by facility staff, volunteers	•	
	= =	nd verbalized understanding.			family members.	, 0.	
		was contact and made			,,		
	report."				On 3/11/18, the Administrator, DON,		
					ADON, QI nurse, MDS-RN and		
		vas interviewed on 3/10/18 at			admissions director began reviewing a		
		icated he was working at the			newly admitted residents upon admiss		
		/18 when he heard Resident			and re-admission for high risk behavior		
	I .	arguing. NA #7 indicated he			The MDS-RN will generate a 48 hour o		
	immediately went to t	the residents. NA#/ d that Resident #2 was in a			plan which includes high risk behaviors).	
	I .	rner with Resident #1 facing			On 3/11/18, the RVP completed trainin	a	
	_	. NA #7 indicated Resident			with the Administrator and DON	9	
		pinned against the wall." NA			regarding: 1) complete root cause		
		rved Resident #1 repeatedly			analysis of resident behaviors, 2) ensu	ring	

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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
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JACOB'S	CREEK NURSING AND F	REHABILITATION CENTER		N	ADISON, NC 27025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD I			(X5) COMPLETION DATE
F 600	Continued From page	e 16	F6	500			
F 600	hitting Resident #2 wi indicted he immediate and Resident #2 and Resident #1 was put interviewed on 3/10/1 indicated on 3/3/18 N Resident #1 hit Resident #1 hit Resident #1 hit Resident #2 were separated and February to one monitoring. Now with Nurse #2 who to second time that wee Resident #2. Nurse #6 acility administrator to Nurse #6 indicated shresponsible party for to the responsible party for to the responsible party was altercation between February Nurse #6 indicated shruse #	reviewed regularly for appropriater and 4) interventions are sustained the IDT and QI review processes or repeated review and updated care planning. The nursing supervisor (Nurse #6) was interviewed on 3/10/18 at 11:30 AM. Nurse #6 indicated on 3/3/18 NA #7 reported to her Resident #1 hit Resident #2 in the face. Nurse #6 stated she immediately made sure the residents were separated and Resident #1 was put on one to one monitoring. Nurse #6 indicated she spoke with Nurse #2 who told her that this was the second time that week Resident #1 had hit Resident #2. Nurse #6 indicated she called the facility administrator to notify her of the event. Nurse #6 indicated she then called the responsible party for Resident #2 and mentioned to the responsible party that she "knew it had happened before." Nurse #6 stated the responsible party was not aware of the previous altercation between Resident #2 and Resident #1.		developed timely, 3) interventions are reviewed regularly for appropriateness, and 4) interventions are sustained throuthe IDT and QI review processes of repeated review and updated care planning. On 3/11/18, the RVP completed training with the IDT behavior team regarding: why the team is meeting, 2) what information the team should look at, 3) how to look at root cause, 4) how to ma recommendations, 5) being proactive a creative, 6) appropriate and sustainable interventions, 7) teaching staff- looking all departments as trainers, 8) looking a resident identification, 9) the "5 Whys" or root cause analysis. On 3/11/18, the RVP completed training with the administrative nurse team titled "Immediate Interventions" which covered	g 1) ake and e at at of		
	she would obtain more back. Nurse #6 indicated she asked Nurse #3 and Resident #2 and Resident #4 and Resident #4 who confirm 3/2/18 from Nurse #3 Resident #1 were in a indicated she asked Noonfirm an altercation Resident #2 and Resident #2 and Resident #4 indicated Nurse #6 ind	ident #1 and did not see any vious altercations between #6 indicated she spoke with ned she received report on that Resident #2 and an altercation. Nurse #6 Nurse #2 to call Nurse #3 to happened between ident #1 prior to 3/3/18. urse #2 sent a text message			1) immediately remove the abused resident, 2) provide constant supervision for the abuser, 3) provide immediate medical intervention, 4) provide immediate redirection techniques as developed by the IDT behavior team, 5 plan of corrections, what broke, why, audit, training, monitoring. On 3/11/18, the DON, ADON, QI Nurse MDS-RN, Infection Control Nurse, and Staff Facilitator, began training all staff how to provide immediate interventions for resident to resident altercations success. 1) immediate protection of residents	on s h	
	Nurse #6 indicated Note to Nurse #3 who conf					h s,	

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JACOB'S	CREEK NURSING AND I	REHABILITATION CENTER		M	IADISON, NC 27025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
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	Nurse #3 stated she is back and confirmed for altercation had happed assessed the injuries indicated she observed the nose and a red syface" that appeared to incident. Nurse #6 incident. Nurse #6 incident. Nurse #6 incident. Nurse #6 incident. Nurse #8 incident. Nurse #8 incident. Nurse #2 and Nurse #8 message from Nurse message from Nurse had happened betwee Resident #2 prior to 3 text messages indicated Nurse #3 she needed documentation of skir reports as well as not resident representative altercation. Nurse #2 confirmed in 4:40 PM that Nurse #3 on 3/3/18. Nurse #2 in Nurse #3 on 3/3/18 are incident report for between Resident #2 revealed she did not between the resident occurred. Nurse #2 comonitoring of Resident Resident #1 hit Resident week.	called the responsible party or him that a previous and. Nurse #6 indicated she of Resident #2. Nurse #6 ed a bruise on the bridge of bot "some other place on her to be from a previous dicated Resident #2 had uising to the right side of her ator on 3/10/18 at 12:30 PM tot of text messages between #3 on 3/3/18. A text #3 confirmed an altercation en Resident #1 and 8/3/18 on a Wednesday. The ted Nurse #2 was informing it to back date in assessments and incident tify administrative staff and wes regarding the 2/28/18 In an interview on 3/10/18 at 16 asked her to call Nurse #3 indicated she did speak with and told her she needed to do the altercation she observed and Resident #1. Nurse #2 know when the altercation is Nurse #3 observed onfirmed that one on one int #1 began on 3/3/18 after lent #2 for the second time			aggressive resident to protect others, 3 notify supervisor/nurse, and 4) follow supervisor/nurse's direction. All staff we ducated prior to working their next scheduled shift by 3/15/18. Any newly hired staff members will be educated of immediate interventions in orientation. The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements. The ADON, MDS-RN and Restorative Nurse will utilize audit tool to ensure continued compliance with protection of cognitively impaired residents from physical abuse inflicted by cognitively impaired residents. These audit tools were completed daily 5 times a week for weeks, weekly for 4 weeks, monthly formonths. The title of the person responsible for implementing the acceptable plan of correction The Administrator is responsible for the implementation of the acceptable plan correction.	were at hat cted by of will 4 r 4	
	an incident report for between Resident #2 revealed she did not between the resident occurred. Nurse #2 c monitoring of Resident Resident #1 hit Resident week.	the altercation she observed and Resident #1. Nurse #2 know when the altercation s Nurse #3 observed onfirmed that one on one nt #1 began on 3/3/18 after			implementation of the acceptable plan		

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		1	TREET ADDRESS, CITY, STATE, ZIP CODE 721 BALD HILL LOOP IADISON, NC 27025			
(X4) ID PREFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED T		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TION SHOULD BE COMPL THE APPROPRIATE DA				
F 600	Resident #1 hit Resfacility Administrator put Resident #1 on the police, call the rice to look for another radministrator indicates Resident #1 had a president #2 earlier Administrator called for Resident #1 to may a solution of the facility and spoke the facility and spoke the facility and spoke the Administrator solution of the Administrator of Resident #1 on Wednesday, stated the sheriff's of physicians were not administrator stated 3/3/18 24 hour on on urrsing staff. The Anot aware of the 2/2 #1 struck Resident #2 from Radministrator stated 3/3/18. The Administrator stated and aware of the 2/2 #1 struck Resident #2 from Radministrator stated and savere for Resident #2 was seassessment of injurrecord for Resident was assessible to the right cheek.	at 5:59 PM and informed her sident #2 in the face. The r stated she told Nurse #6 to one to one observation, call esident representatives, and room for Resident #1. The sted that Nurse #6 notified her previous altercation with in the week. The I the resident representative solify her of the events of estrator stated she then went to see with Nurse #2 and NA #7. Itated she was informed by the told the resident esident #2 that an altercation are Resident #2 and Resident 2/28/18. The Administrator	F	600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345050	B. WING _			C 03/14/2018
	ROVIDER OR SUPPLIER CREEK NURSING AND I	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025		00/14/2010
(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 COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	Continued From page	e 19	F	600		
	included bruising to the mark on the chin and complained of pain at as needed pain medition as needed pain medition. A nursing note dated still had bruising on hose. The resident congiven as needed pair effective. An observation and it is 3/9/18 at 12:09 PM regreen bruise under his did not know how the hurt when she touched.					
	3/9/18 at 10:26 AM. To be lying in bed with sitting outside of his on NA #8 was interviewed observation and indiction of the door of Reside monitor the resident. The had happened last woreated for the monitor stated Resident #1 whis room but she would chose to do so. An interview was continued in the work of the monitor the monitor the monitor stated Resident #1 whis room but she would have been do so. An interview was continued in the monitor the monitor in the monitor of the mo	sident #1 was made on The resident was observed in a staff member (NA # 8) door in the hallway in a chair. The dat the time of the stated someone was outside int #1 24 hours a day to NA#8 indicated something the ekend and a rule was foring of Resident #1. NA #8 the as allowed to come out of all have to follow him if he diducted with the Director of 10/18 at 9:55 AM. The DON on between Resident #1 and inted on the 24 hour report and not been investigated is survey. The DON also				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345050	B. WING		C 03/14/2018		
	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 DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 600	Resident #1 resided injuries after 3/2/18. The facility DON was 4:00 PM. She stated reporting, notification documentation of alt was given to the number of acility. The DON sainurses immediately residents into account then expected to not Administrator, the rephysicians of any residents and initial multidisciplinary tear interventions or action of 3/10/18 at 12:40 informed of the immer provided a credible at 3/11/18 at 7:36 PM. indicated: Credible Allegation of Jacob's Creek Nursing was placed into Immer 10, 2018, for abuse, deficiency was deter communication. Prior to the incident of exhibited behaviors of other residents in se assessed each incident.	esidents on the hallway where had not been assessed for a sinterviewed on 3/9/18 at her expectations for not family, and ercations between residents ses during orientation to the dit was her expectation the take the safety of the nt. She said the nurses were if yeither the DON or the sident's family and the sident altercations. The DON expected to document the te incident reports so that the no could identify what ons were necessary. PM the Administrator was ediate jeopardy. The facility allegation of compliance on The allegation of compliance	F 60				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345050	B. WING		C 03/14/2018	
	ROVIDER OR SUPPLIER CREEK NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025	1 33/14/2010	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 600	behaviors. The fac interventions based ineffectiveness. As of 3/11/18, the fadesigned for a syste examination into: 1 behaviors, 2) the tra 3) creation of applicinterventions for reseffective training of interventions to decibehaviors. On 3/2/18, there wa #1 hit another reside What is the facility's specific deficiency? On 2/5/18, 15 minurintervention for Resa resident-to-reside resident. Resident and redirected with On 3/2/18 at 5:30pr Resident #1's electrontinues on 15 min behaviors at this tin Resident #1 was macheck schedule. The between the 15 min time of the incident was struck by Resident was struck by Resident was the struck by Resident was struck	acility created a process ematic, predictable or to causes for resident acking of resident behaviors, able and sustainable sident behaviors, and 4) facility staff regarding crease the potential of resident ent, including Resident #2. Is plan for correcting the te checks began as an ident #1's behaviors regarding int altercation with another #1 was immediately removed 15 minute checks instituted. In, Nurse #2 documented in ronic health record "Resident interchecks with no new	F 600			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345050	B. WING _			C 03/14/2018
	ROVIDER OR SUPPLIER CREEK NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1721 BALD HILL LOOP MADISON, NC 27025	ODE	1 00/14/2010
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BI THE APPROPRIA	
F 600	minute check was not Resident #2 from about opportunity to redired Resident #2 prior to a composition of the	ause analysis why the 15 of effective in preventing use: staff missed the ct Resident #1 away from the incident. mately 5:58 pm, Certified NA) #7 observed Resident 2 in the face. CNA #7 ed, separating Resident #2 NA #7 called down the hall mediately came to assist 7 stayed with Resident #1. mately 6:00pm, Nurse #6 2 with bruises to her face. ealed areas on Resident #2's t eye, that were red. Also, abrasions, one above the low the lower lip, ze of a pencil eraser, not sked Resident #2 if she was hurting. Resident #2 ille. Resident #2 had no ked look on her face. mately 6:03pm, Nurse #6 ained with Resident #1, upervision. Nurse #6 ealed with Resident #1 upervision. Nurse #6 ealed Resident #1 had	F6			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345050	B. WING			C 03/14/2018		
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025	<u> </u>	03/14/2010		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 600	interviewed Resided deputy instructed Rallowed to hit other enforcement officer determined no other left satisfied with the were in place for Ron 3/3/18 at appronotified Resident # (RR) of the resident altercation and Resident discolorations. Resident of the facility. On 3/3/18 at 6:50pt the facility and visit declined Nurse #6's #2 to the hospital for offer to have in-hour offer to have in-hour offer to have in-hour offer to have in-hour on 3/3/18, Nurse # Resident #2's RR to hospital for evaluate CT scan and x-rays called Nurse #6 and results had no negation of the office for an interceived a telephor requesting a meeting interview with Nurse and ask Nurse #3 in resident altercation in the	y, looked at Resident #2, and nt #1 twice. The sheriff's desident #1 that he is not residents. The law is assessed the situation and er actions were required, they defacility interventions that desident #1 and Resident #2. Eximately 6:13pm, Nurse #6 2's resident representative it to resident physical dident #2's facial dident #2's RR stated he would with Resident #2. The RR is suggestion to send Resident and declined and declined and declined and declined and declined and declined consent from the send Resident #2 to the dident #2. The hospital declined Resident #2. The hospital declined Resident #2. The hospital declined Resident #2's test	F 6					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345050	B. WING			C 3/14/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP		13/14/2016		
JACOB'S	CREEK NURSING AND	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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 600	by the administrator, knew who Resident # Nurse #3 also reveal Nurse #2 the altercat Resident #1 and Res the shift on 2/28/18. Nurse #3 to re-enact altercation on 2/28/18 how Resident #1 "bo nose with a fist, in a cadministrator asked I keep (Resident #2) a Nurse #3 replied that issues the rest of the his room, and Nurse Nurse #3. The admin notifications were not documentation, and I Nurse #3 stated it ha nurse got busy, and I administrator initiated registered nurses (RI nurses (LPNs), include "You must in all chain."	In not know". After prompting Nurse #3 revealed that she #1 and Resident #2 were. ed Nurse #3 had reported to ion occurred between ident #2 at the beginning of The administrator asked what happened during the B. Nurse #3 demonstrated opped" Resident #2 on the downward motion. The Nurse #3 "what did you do to not everyone else safe?" they didn't have any more day, Resident #1 stayed in #3 kept Resident #2 with histrator told Nurse #3 that is made, there was no here was no incident report. In ppened early in the shift, the he nurse "forgot." The I re-education of all Ns) and licensed practical ding Nurse #3:	F 6	00				
	MD and put intervent ensure that the safety immediate and head be documented. In the MUST notify the DON directions on how to may result in discipling On 3/8-9/18, Social W#2 initiated interviews residents. The social	to toe assessments MUST ne event of altercation, you Wor the administrator for proceed. Failure to do so						

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			03/	14/2018
	ROVIDER OR SUPPLIER CREEK NURSING AND I	REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE 1721 BALD HILL LOOP MADISON, NC 27025	E, ZIP CODE	301	20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI' CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page 2) Has anyone, include feel unsafe or threater including another resunsafe or threatened report it to? The internegative findings. On 3/8/18, the adminimprovement (QI) mewas being done to prove the president #1 from the residents, 3) the to resident altercation. On 3/10/18 at approximation administrator instruct (DON) to continue Resupervision, 24 hours interdisciplinary (IDT) 1:1 supervision is no behavior team will revise behavior residents, to Resident #2. The ID weekly for six (6) more maintaining of application the need for continue the supervision is no page 1.	ding residents, made you ned you? 3) If someone, ident, were to make you feel you do you know who to rviews resulted in no distrator facilitated a quality eting to discuss: 1) what otect Resident #2, 2) how to me having altercations with erroot cause of the resident at a discussion of nurses. Similarly 1:30pm, the ded the director of nursing esident #1 on 1:1 as per day, until the behavior team determines longer necessary. The IDT view and discuss high risk of include Resident #1 and T behavior team will meet					
	teams of the assistan and CNA #2, quality i restorative nurse, and CNA #3 completed a non-alert and oriented assessment findings root cause analysis, o outcome of the skin a that required submiss	imately 2:30pm, clinical t director of nursing (ADON) mprovement (QI) nurse and the RN supervisor and 100% skin assessment on diresidents. The skin were given to the DON for completed 3/12/18. The assessment was no findings sion to the Health Care entified during the skin					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		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		3/14/2018	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	audit of the nurse prothrough 3/10/18, 6pn (1) event that the add Health Care Registry On 3/10/18 at appropadministrator complemanagement incider 2/23/18 through 3/10 incidents/accidents to follow-up related to revealed eight (8) incimplemented approproom changes, mediclinical interventions. What procedure was of the specific deficie On 3/10/18 at approvice president (RVP) with the administrator responsibility of the accomplete 24 hour and Care Registry. On 3/10/18 at approveducated the administrator the administrator department heads (Cadministrator's assis social workers, medipayable, accounts responsible, accounts responsibl	S-RN completed a 100% ogress notes from 2/23/18 in. The audit identified one ministrator submitted to the vas a 24 hour report. It is a 100% audit of the risk of a 100%	F 60				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED	
		345050	B. WING			C	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025		3/14/2018	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	Continued From page Allegations of Reside checklist. ALLEGATIONS OF FABUSE Allegations of Reside verbal, or sexual abuthe Administrator she incident occurs or as reported. The Administrator will the investigation will the investigation will the Administrator will on Regional V.P. To Other Corporate directed by Regional on Take immediate residents: Remove/separate on Monitor location information is obtained on Complete Reside electronic health recommon management portation on Interview the "action of the resident as a confirmation is of the resident as a confirmation and the resident as a confirmation and the resident as a confi	e 27 Int to Resident Abuse RESIDENT TO RESIDENT Int to Resident physical, se will be reported timely, ould be informed timely after soon as the allegation is I direct the investigation, begin timely. I notify: staff as appropriate or V.P. steps to protect the residents of each resident until more and regarding the incident ent Q.I. Reporting form (in ords system - Risk or as needed, BN-9038) becused" resident and the	F 6	DEFICIENCY)			
	make you feel""? o Obtain written w o Interviewable res o Employees that o Employees in the	sical assessment; document					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION		X3) DATE COMP	SURVEY LETED
		345050	B. WING _				03/	C 14/2018
	ROVIDER OR SUPPLIER CREEK NURSING AND F	REHABILITATION CENTER		1721 I	ET ADDRESS, CITY, STATE, ZIP CODE BALD HILL LOOP ISON, NC 27025	<u> </u>		14,2010
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		Ē	(X5) COMPLETION DATE
F 600	State agency, Adult F Ombudsman as indice notify State agency a immediately. o Allegations of se "rape kit" to be comple (per physician directive Sexual Abuse, Abuse Misappropriation of R information (Administ Facility Guidelines (Vous Corrective measus Regional V.P. Exame Review and revise Discharge from formation (30) minute audits New medications Review/analysis of hime Retraining of state Consultant referred 1:1 monitoring o Points to Remement o It is important that seriously and investige Establish investige Establish investige Establish investige Encourage all state related to resident to o Departments sho Corrective measus o Notify Regional Notonsultants as directed	with Regional V.P., notify Protective Services, or ated, except in Kentucky - and Adult Protective Services exual abuse may indicate a eted at the hospital (e). Refer to Allegation of the Regional Property for further rative Policies Manual). Persion Date: 11/2013) cures will be discussed with inples: sion of MDS and care plan acility her unit less or hourly Q.I. observation of story/pattern of allegations of the first all allegations are taken patted timely grative file in your office aff to report any concerns resident abuse ould communicate concerns ures must be initiated difference of the pattern of the protection of the properties of the pattern of the	F	600				

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				C
NAME OF PI	ROVIDER OR SUPPLIER	040000		STREET	ADDRESS, CITY, STATE, ZIP CODE	03/	14/2018
JACOB'S	CREEK NURSING AND F	REHABILITATION CENTER			ALD HILL LOOP ON, NC 27025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page 29		F	600			
	administrator initiated department heads regardinistrative oversignesident altercation. On 3/10/18 at approx ADON, QI nurse, and began educating 100 assistants, and geriat on documentation expectations: Docum o24 hour report sheet incidents, accidents, altercation, abuse, neolncident reports - co MD notification - in addinursing staff is required of expect anyone with including resident to redirectly contact the accolumn o24 hour reports - co MD notification - in addinursing staff is required of expect anyone with including resident to redirectly contact the accolumn o24 hour reports and resident to redirectly contact the accolumn o25 hours and o16 hours of immediately then call safety is our #1 priority. On 3/11/18, the adminurse, MDS nurse, Resident and of staff on how to sup residents at high risk resident altercation.	an education for all garding the prevention and ght of abuse/resident to imately 6:30pm, the DON, infection control nurse of RNs, LPNs, nursing ric care assistants (GCAs) pectations: Inentation, I expect: Its - date, sign, shift, notes on resident to resident eglect. Impleted before leaving shift, otification, and document place. Ition to notifying MD & RR, ed to notify their supervisor. Inessing resident abuse, should diministrator. Inestitute of the resident physically control, call 911 In the administrator. Resident ty! Inistrator, DON, ADON, QI In charge nurse, social ager, weekend manager on the consultant educated 100% inervise and monitor					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(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 00/14/2010		
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F 600	nurse, MDS-RN, soc IDT behavior team mesidents through the admission paperwork incident report review 5) 24 hour report she medical information. interventions to reduce and to provide focuse behavioral residents. Beginning 3/11/18, the ADON, QI nurse, soc facilitator will educate orientation regarding what to watch for, who report to, and what to watch for, who report to, and what the IDT behavior 3/11/18 meeting. The families for ideas to concupation skills, hot recommendations from the IDT behavior occupation skills, hot recommendations from the IDT behavior occupation skills, hot recommendations from the care planned activity department where care planned activity depar	inistrator, DON, ADON, QI ial worker began a weekly iseting to identify and review is following criteria: 1) ix, 2) progress note review, 3) ix, 4) social work note review, ite review, 6) other pertinent The facility will implement the facility will implement the the risk of abuse incidents and supervision of high risk the administrator, DON, cial worker, and/or staff the newly hired staff during high risk behavior residents, that to do, when to report, who to document. The activities director will the activities director will ask to coupy high risk residents ous likes, previous	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER CREEK NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1721 BALD HILL LOOP MADISON, NC 27025		03/14/2018		
(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 ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 600	administrator and DO root cause analysis of ensuring that approphedeveloped timely, 3) regularly for appropriare sustained throug processes of repeated planning. On 3/11/18, the RVP IDT behavior team remeeting, 2) what infoliook at, 3) how to loo make recommendatic creative, 6) appropriative networking, 7) tead departments as trainidentification, 9) the sanalysis On 3/11/18, the RVP administrative nurse Interventions" which remove the abused resupervision for the amedical intervention, redirection technique behavior team, 5) play why, audit, training, in the control of the control o	completed training with the DN regarding: 1) complete of resident behaviors, 2) riate interventions are interventions are reviewed fateness, and 4) interventions in the IDT and QI reviewed review and updated care completed training with the regarding: 1) why the team is sormation the team should sk at root cause, 4) how to ons, 5) being proactive and read at and sustainable ching staff- looking at all res, 8) looking at resident '5 Whys" of root cause completed training with the ream titled "Immediate covered: 1) immediately resident, 2) provide constant buser, 3) provide immediate 4) provide immediate as as developed by the IDT an of corrections, what broke, monitoring.	F 6					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	COMPLETED		
		345050	B. WING		C 03/14/2018	
	ROVIDER OR SUPPLIER CREEK NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025	1 33/1-1/2313	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 600	allowed to work unto The facility's credible was verified by the 4:52 PM as evidence residents, record residents, record residents, record resident Records - CFR(s): 483.20(f)(5) Resident Records - CFR(s): 483.20(f)(5) Resident Records resident r	In 1/18, no facility staff will be il this in-service is completed. It is in-service is completed. It is allegation of compliance survey team on 3/14/18 at beed by observations of view of employee training, for residents and family. Identifiable Information (a), 483.70(i)(1)-(5) In the information that is the tothe public. In the public is the public is to an agent only in contract under which the agent is the facility itself is permitted in the facilit	F 60	0	4/6/18	
	§483.70(i)(1) In acc professional standa must maintain medi that are- (i) Complete; (ii) Accurately docur (iii) Readily accessi (iv) Systematically of §483.70(i)(2) The fa all information contar regardless of the for records, except who (i) To the individual,	cordance with accepted and practices, the facility ical records on each resident imented; ble; and organized acility must keep confidential ained in the resident's records, rm or storage method of the en release is-				

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 03/14/2018	
	PROVIDER OR SUPPLIER CREEK NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1721 BALD HILL LOOP MADISON, NC 27025	I	03/14/2010	
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 842	(iii) For treatment, paragraphs operations, as permined with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purpurposes, research predical examiners, for a serious threat to he by and in compliance §483.70(i)(3) The fact record information accurate for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yelegal age under State §483.70(i)(5) The me (i) Sufficient informat (ii) A record of the record informat (iii) The comprehens provided; (iv) The results of an and resident review of determinations condict (v) Physician's, nurse professional's progrecy (vi) Laboratory, radio services reports as rethis REQUIREMENT by:	lyment, or health care steed by and in compliance steed by and in compliance, violence, health oversight steed administrative proceedings, poses, organ donation ourposes, or to coroners, uneral directors, and to avert eath or safety as permitted eath of safety as permitted eath 45 CFR 164.512. Stillity must safeguard medical gainst loss, destruction, or are date of discharge when ent in State law; or are after a resident reaches e law. Sedical record must containtion to identify the resident; sident's assessments; ive plan of care and services by preadmission screening evaluations and cucted by the State; e's, and other licensed	F8	Jacob's Creek acknowledges re	acaint of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			، ا	C	
		345050	B. WING				14/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 00,	2010	
				17	721 BALD HILL LOOP			
JACOB'S	CREEK NURSING AND I	REHABILITATION CENTER		M	IADISON, NC 27025			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 842	Continued From page	F	842					
	facility failed to have	accurate and complete			the Statement of Deficiencies and			
		medical record of a resident			proposes this Plan of Correction to the			
	to resident altercation	n for 2 of 5 residents			extent that the summary of findings is			
	reviewed for complete	e and accurate records			factually correct and in order to maintain	n		
	(Resident #1 and Res	sident #2).			compliance with applicable rules and			
					provisions of quality of care of resident			
	The findings included	l:			The Plan of Correction is submitted as	а		
					written allegation of compliance.			
	I .	dmitted to the facility on						
	_	s of dementia, anxiety			Jacob's Creek response to this Statem	ent		
	disorder, cerebrovaso				of Deficiencies does not denote			
	1 -	terly minimum data set ated 12/27/17 revealed			agreement with the Statement of Deficiencies nor does it constitute an			
		erely cognitively impaired			admission that any deficiency is accura	ıto.		
	I .	ssistance with bed mobility,			Further, Jacob's Creek reserves the rig			
		irment of lower extremities,			to refute any of the deficiencies on this			
		comotion on the nursing unit.			Statement of Deficiencies through			
					Informal Dispute Resolution, formal			
	Record review of a 24	4 hour report dated 3/2/18			appeal procedure and/or any other			
	for second shift (3:00	PM to 11:00 PM) completed			administrative or legal proceeding.			
	by Nurse #2 indicated	d a nursing report was						
		#3 on first shift (7:00 AM to			F842 Resident Records – Identifiable			
	3:00 PM) that Reside in an altercation.	ent #2 and Resident #1 were			Information			
					The plan of correcting the specific			
	Nurse #2 was interview	ewed on 3/9/18 at 4:40 PM.			deficiency			
	Nurse #2 indicated sh	ne received report from						
	Nurse #3 on 3/2/18 a	t the change of shift that			The position of Jacob's Creek Nursing			
		ion between Resident #2			and Rehabilitation Center regarding the			
		rse #2 indicated she did not			process that lead to this deficiency; the			
	1	I in the altercation or when it			facility failed to have accurate and			
		ndicated she made the			complete documentation in the medica			
	· ·	quired documentation			record of a resident to resident altercat			
		tion and the assessment had ted on the first shift (7:00 AM			for 2 of 5 residents reviewed for comple and accurate records. Facility nurse di			
	to 3:00 PM) on 3/2/18				not ensure that she documented	u		
	10 0.00 FIVI) OH 3/2/10	J.			accurately and completely in the medic	al		
	Nurse #3 was intervie	ewed on 3/9/18 at 3:52 PM.			record for Resident #2 and Resident #			
		she did give report to Nurse			133514 101 13314511 #2 and 13314611 #			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		C		
		345050	B. WING				/14/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
IACOBIC	CDEEK MUDGING AM	D DELIADII ITATION CENTED		17	721 BALD HILL LOOP			
JACOB'S	CREEK NURSING AN	D REHABILITATION CENTER		M	IADISON, NC 27025			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	'	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 842	Continued From pa	age 35	F	842				
	-	r 7:00 AM to 3:00 PM shift on		·	Jacob's Creek Nursing and Rehabilitati	on		
		altercation that had occurred			Center's plan for correcting the deficier			
		#2 and Resident #1. Nurse #3			is to ensure that the facility has accurat			
		on occurred between 9:00 AM			and complete documentation in the			
		se #3 stated, "I did not write a			medical records to include Resident #2			
	note at that time bu	it thought I would later write a			and Resident #1.			
	note after I finished	I my medication pass. I did						
		ncoming nurse at the end of			The procedure for implementing the			
		#2]." Nurse #3 indicated she			acceptable plan of correction for the			
	did not notify anybo			specific deficiency cited				
	Resident #2 and Re			0 04040040 1400 514	.,			
	on 3/2/18. Nurse #3			On 3/10/2018, MDS-RN reviewed 1009	6			
	, · •	n incident report on 3/2/18.			progress notes from 3/2/2018 through			
		she could not recall the exact between Resident #2 and			3/10/2018 to ensure accurate and complete documentation in the medica	ı		
	1 -	ned, she thought it was on a			records. The audit resulted in no nega			
	Wednesday (2/28/	-			findings.			
		ical records of Resident #2 did			On 3/10/18 the DON, ADON, QI nurse,			
	· ·	umentation regarding an			and Infection Control Nurse began			
		n Resident #1 and Resident #2			educating all nursing staff members on			
	on 3/2/18.				documentation expectations with regar	ds		
	December 1	and the second s			to resident to resident altercations and			
		ne nursing notes for Resident			documentation. All nursing staff member			
		ated, "Resident was sitting at ne dining room when another			were educated prior to working their ne scheduled shift by 3/15/18. Any newly			
		e dining room when another elling self into the dining room.			hired nursing staff members will be			
	1	ing assistant) observed other			educated on documentation expectatio	ns		
	,	resident in the face with a fist.			to include accurate and complete	110		
	_	parated. Administer was			documentation in the medical records i	n		
		(7:01 PM). RR (Resident			orientation.			
		ame] was contact at 1910						
		de a visit to the facility and			The monitoring procedure to ensure the	at		
		anding. Deputy and detective			the plan of correction is effective and the			
	was contact and m	ade report."			specific deficiency cited remains correct			
					and/or in compliance with the regulator	У		
		an incident report for Resident			requirements			
		ated, "Resident was sitting in			TI ABON MBO EN 15 1 "			
	∣ hallway at entrance	e to dining room. CNA			The ADON, MDS-RN and Restorative			

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				C 14/2018	
NAME OF PI	ROVIDER OR SUPPLIER	0.0000	1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	14/2016	
JACOB'S	CREEK NURSING AND I	REHABILITATION CENTER			721 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 PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 842	REGULATORY OR LSC IDENTIFYING INFORMATION)				Nurse will utilize audit tool to ensure continued compliance with accurate an complete documentation in the medica records. These audit tools will be completed daily 5 times a week for 4 weeks, weekly for 4 weeks, monthly formonths. The title of the person responsible for implementing the acceptable plan of correction The Administrator is responsible for the implementation of the acceptable plan correction.	1 r 4		
	#6 indicated NA #7 re hit Resident #2 in the she spoke with Nurse was the second time hit Resident #2. Nurs unable to locate any medical record regard between Resident #2 medical records. The facility Administra	ident #1 were located. Nurse eported to her Resident #1 face. Nurse #6 indicated #2 who told her that this that week Resident #1 had e #6 indicated she was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345050	B. WING			C 03/14/2018	
NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP C 1721 BALD HILL LOOP MADISON, NC 27025	ODE	03/14/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	had happened betwee Resident #2 prior to text messages indicated Nurse #3 she needed documentation of sk reports as well as not resident representation. Nurse #2 confirmed 4:40 PM that Nurse #3 on 3/3/18. Nurse #2 Nurse #3 on 3/3/18 an incident report for between Resident #2 revealed she did not between the residen occurred. The facility Administration 3/10/18 at 8:36 AM. called her on 3/3/18 Resident #1 had a period Resident #1 had a period Resident #2 earlier in Administrator stated #6 that the she told to the Resident #2 that an incident #2 that an incide	#3 on 3/3/18. A text #3 confirmed an altercation een Resident #1 and 3/3/18 on a Wednesday. The ated Nurse #2 was informing d to back date in assessments and incident diffy administrative staff and een regarding the 2/28/18 in an interview on 3/10/18 at #6 asked her to call Nurse #3 indicated she did speak with and told her she needed to do the altercation she observed and Resident #1. Nurse #2 know when the altercation ts Nurse #3 observed ator was interviewed on She indicated Nurse #6 at 5:59 PM and informed her dent #2 in the face. The ed that Nurse #6 notified her revious altercation with the week. The she was informed by Nurse the resident representative of altercation had occurred and Resident #1 on	F	842			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		` ′	(X3) DATE SURVEY COMPLETED		
	345050	B. WING			C 03/14/2018		
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		03/14/2010		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE		
The incident report had a nursing descripted arguing with this respelling "get out of modek" someone shoresident in the face/resident reports this However, both resident reports this However, both resident reports this However, both resident report date altercation." An interview with the 10:44 AM revealed incident report date 3/7/18. The QI nurs and the Director of incident report date 3/8/18. Record review rever documentation in the #2 for the events defincident report. The facility DON was 4:00 PM. She stated reporting, notification documentation of all was given to the nute facility. The DON sate to document physic incident reports so the could identify what increasary.	for Resident #2 dated 2/28/18 ription of the incident that ent observed in hallway sident. Male resident heard by room" This resident yelled bot him." Male resident hit this rose with his hand. Male resident was in his room. dents were observed in the resident's room at time of e QI nurse on 3/10/18 at she reviewed and revised the d 2/28/18 on Wednesday, re revealed the Administrator hursing signed off on the d 2/28/17 on Thursday, aled there was no re medical record of Resident rescribed on the 2/28/18 as interviewed on 3/9/18 at d her expectations for for of family, and recreations between residents rese during orientation to the aid the nurses were expected al altercations and initiate that the multidisciplinary team interventions or actions were	F 84	2				
3/10/18 at 8:36 AM.	She stated her expectations						
	CREEK NURSING AND SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From pa The incident report had a nursing description and the series of th	ROVIDER OR SUPPLIER CREEK NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 The incident report for Resident #2 dated 2/28/18 had a nursing description of the incident that stated, "Male resident observed in hallway arguing with this resident. Male resident heard yelling "get out of my room" This resident yelled back "someone shoot him." Male resident hit this resident reports this resident was in his room. However, both residents were observed in the hallway outside of resident's room at time of altercation." An interview with the QI nurse on 3/10/18 at 10:44 AM revealed she reviewed and revised the incident report dated 2/28/18 on Wednesday, 3/7/18. The QI nurse revealed the Administrator and the Director of Nursing signed off on the incident report dated 2/28/17 on Thursday, 3/8/18. Record review revealed there was no documentation in the medical record of Resident #2 for the events described on the 2/28/18 incident report. The facility DON was interviewed on 3/9/18 at 4:00 PM. She stated her expectations for reporting, notification of family, and documentation of altercations between residents was given to the nurses during orientation to the facility. The DON said the nurses were expected to document physical altercations and initiate incident reports so that the multidisciplinary team could identify what interventions or actions were	ROVIDER OR SUPPLIER CREEK NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 The incident report for Resident #2 dated 2/28/18 had a nursing description of the incident that stated, "Male resident observed in hallway arguing with this resident. Male resident heard yelling "get out of my room" This resident heard yelling "get out of my room" This resident hit this resident in the face/nose with his hand. Male resident reports this resident was in his room. However, both residents were observed in the hallway outside of resident's room at time of altercation." An interview with the QI nurse on 3/10/18 at 10:44 AM revealed she reviewed and revised the incident report dated 2/28/18 on Wednesday, 3/7/18. The QI nurse revealed the Administrator and the Director of Nursing signed off on the incident report dated 2/28/17 on Thursday, 3/8/18. Record review revealed there was no documentation in the medical record of Resident #2 for the events described on the 2/28/18 incident report. The facility DON was interviewed on 3/9/18 at 4:00 PM. She stated her expectations for reporting, notification of family, and documentation of altercations between residents was given to the nurses during orientation to the facility. The DON said the nurses were expected to document physical altercations and initiate incident reports so that the multidisciplinary team could identify what interventions or actions were necessary. The facility Administrator was interviewed on 3/10/18 at 8:36 AM. She stated her expectations	ROWIDER OR SUPPLIER CREEK NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 38 The incident report for Resident #2 dated 2/28/18 had a nursing description of the incident that stated, "Male resident observed in hallway arguing with this resident. Male resident hit his resident reports this resident was in his room. However, both resident's room at time of altercation." An interview with the QI nurse on 3/10/18 at 10.44 AM revealed she reviewed and revised the incident report dated 2/28/17 on Thursday, 3/8/18. Record review revealed there was no documentation in the medical record of Resident #2 for the events described on the 2/28/18 incident report. The facility DON was interviewed on 3/9/18 at 4:00 PM. She stated her expectations between residents was given to the nurses during orientation to the facility, The DON said the nurses were expected to document physical altercations and initiate incident reports so that the multidisciplinary team could identify what interviewed on 3/10/18 at 13:36 AM. She stated her expectations	A BUILDING 345050 34		

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 _			C 03/14/2018		
	NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER			172	REET ADDRESS, CITY, STATE, ZIP CODE 1 BALD HILL LOOP 1.DISON, NC 27025	·	00/	14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE		(X5) COMPLETION DATE
F 842	Continued From page	e 39	F	342				
	physician were to be acknowledged that si to protect Resident # accurate documentat Nurse #3 in a timely 12. Resident #1 was a diagnoses of schizop Alzheimer's disease. 1/11/18 revealed Rescognitively impaired to days of the assessment	ations, the family and the notified. The Administrator teps would have been taken 2 if the complete and tion had been completed by manner prior to 3/3/18. Idmitted on 9/9/09 with ohrenia, dementia, and The quarterly MDS dated sident #1 was moderately with physical behaviors 1 to 3 ent period.						
	records dated 2/23/1. Resident #1 was beir minutes for behavior. (Quality Improvemen AM revealed Resider visual checks since 2							
	Nurse #2 indicated si Nurse #3 on 3/2/18 at there was an altercat and Resident #1. Nur know what happened occurred. Nurse #2 in assumption all the re regarding the alterca been already comple to 3:00 PM) on 3/2/18 Nurse #3 was intervie Nurse #3 confirmed si #2 at the end of her 7	ewed on 3/9/18 at 4:40 PM. the received report from the change of shift that tion between Resident #2 rse #2 indicated she did not in the altercation or when it indicated she made the quired documentation tion and the assessment had ted on the first shift (7:00 AM 8. ewed on 3/9/18 at 3:52 PM. she did give report to Nurse 7:00 AM to 3:00 PM shift on altercation that had occurred						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345050	B. WING _			C 03/14/2018		
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	•	03/14/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE		
F 842	stated the altercation and 10:00 AM. Nurs note at that time but note after I finished in report it off to the on the shift to [Nurse #2 did not notify anybook Resident #2 and Reson 3/1/18. Nurse #3 any progress notes or regarding the altercatindicated she could altercation between happened, she thous Review of the medicate not reveal any documentation between on 3/2/18. Record review of the #1 dated 3/3/18 states with the self into dining room was sitting outside of (Certified Nursing As be punching resident Residents [were] secontacted. [Resident was contacted. 1 on detective where con Room change to 200 Documentation on a #1 dated 3/3/18 state "At [5:58 PM], CNA I hallway in Geri-chair resident was wheeling resident was wheeling and the state of the second resident was wheeling and the state of the second resident was wheeling and the second resident resident resident was wheeling and the second resident res	2 and Resident #1. Nurse #3 n occurred between 9:00 AM e #3 stated, "I did not write a thought I would later write a my medication pass. I did coming nurse at the end of 2]." Nurse #3 indicated she dy of the altercation between sident #1 other than Nurse #2 indicated she did not fill out or an incident reports ation on 3/2/18. Nurse #3 not recall the exact day the Resident #2 and Resident #1 ght it was on a Wednesday. all records of Resident #1 did mentation regarding an Resident #1 and Resident #2 e nursing notes for Resident ed, "Resident was propelling where other (Resident #2) of dining room area. CNA esistant) observed resident to t in the face with a fist. carated. Administer was t Representative] case worker 1 put in place. Deputy and tacted to come to facility.	F	342				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345050		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345050	B. WING _			C 3/14/2018	
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		3/14/2010	
(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 ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO TIED DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	female resident in the fist. Upon this nurse or resident was in the diresident he hit was si asked why he hit the the hell out" and start attempting to hit staff. Nurse aide (NA) #7 vident and Resident #1 attempting to hit staff. Nurse aide (NA) #7 vident attempting to hit staff. Nurse aide (NA) #7 vident attempting to hit staff. Nurse aide (NA) #7 vident attempting to hit staff. Nurse aide (NA) #7 vident attempting to hit staff. Nurse aide (NA) #7 vident attempting to hit staff. Nurse aide (NA) #7 vident attempting to hit staff. #2 and Resident #1 was put attempting to hit staff. #3 indicated he observer reclining chair in a context and Resident #2 windicated he observer reclining chair in a context and Resident #2 and Resident #1 was put. The nursing supervising interviewed on 3/3/18 shappening so she were Resident #2 and Resident #1 in the she spoke with Nurse was the second time hit Resident #1. Nurse was the second time hit Resident #1. Nurse unable to locate any medical record of Resident #1.	witnessed this resident hit e face with his hands into a observing the scene, this ining room and female titing in the hallway. When resident he told me to "get ted swinging at nurse ." vas interviewed on 3/10/18 at icated he was working at the /18 when he heard Resident arguing. NA #7 indicated he the residents. NA #7 d that Resident #2 was in a armer with Resident #1 facing . NA #7 indicated Resident pinned against the wall." NA rved Resident #1 repeatedly ith his fist in her face. NA #7 ely separated Resident #1 one to one monitoring of in place. or (Nurse #6) was 18 at 11:30 AM. Nurse #6 he heard something was ent to the unit where ident #1 were located. Nurse exported to her Resident #2 face. Nurse #6 indicated e #2 who told her that this that week Resident #2 had e #6 indicated she was documentation in the	F	342			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345050	B. WING				C / 14/2018	
	NAME OF PROVIDER OR SUPPLIER JACOB'S CREEK NURSING AND REHABILITATION CENTER			172	EET ADDRESS, CITY, STATE, ZIP CODE 1 BALD HILL LOOP DISON, NC 27025	1 00/	14/2010	
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 842	provided a screen she Nurse #2 and Nurse #3 message from Nurse had happened betwee Resident #2 prior to 3 text messages indicated Nurse #3 she needed documentation of skir reports as well as not resident representatival altercation. Nurse #2 confirmed in 4:40 PM that Nurse #3 on 3/3/18. Nurse #2 in Nurse #3 on 3/3/18 a an incident report for between Resident #2 revealed she did not between the residents occurred. The facility Administration occurred.	ator on 3/10/18 at 12:30 PM of text messages between #3 on 3/3/18. A text #3 confirmed an altercation en Resident #1 and 13/3/18 on a Wednesday. The ted Nurse #2 was informing I to back date in assessments and incident ify administrative staff and wes regarding the 2/28/18. In an interview on 3/10/18 at 16 asked her to call Nurse #3 indicated she did speak with and told her she needed to do the altercation she observed and Resident #1. Nurse #2 know when the altercation is Nurse #3 observed. Ator was interviewed on She indicated Nurse #6 indicated Nurse indicated N	F	842				
		ents that occurred on						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(>	(X3) DATE SURVEY COMPLETED			
		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			03/14/2018		
(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)	SHOULD BE	(X5) COMPLETION DATE		
F 842	2/28/18. The incident report for had a witness statem "Resident was in the with another resident them arguing, he said yelled, someone sho [Resident #1] hit [Resident #1] hi	or Resident #1 dated 2/28/18 nent from Nurse #3, hallway and verbally arguing to the IRE in the IRE	F8	342				