STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345050	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JACOB'S CREEK NURSING AND REHABILITATION CENTER	1721 BALD HILL LOOP MADISON, NC 27025

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to notify the physician of abnormal laboratory results for 1 of 2 (Resident #111) reviewed for pressure ulcers. The findings included: Resident #111 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A non-ulcer skin condition flow sheet dated 1/6/20 revealed Resident #111 had an open area to her left hand at her thumb that was excoriated with moderate [DIAGNOSES REDACTED] and a moderate amount of serosanguinous drainage. The flowsheet indicated there were signs of infection and a culture of the drainage was to be obtained. A record review revealed a laboratory culture report dated 1/11/20 from a wound culture of Resident #111 ' s left hand at the thumb that was collected on 1/7/20. The wound culture showed [MEDICAL CONDITION] (MRSA). A record review revealed no documentation of the physician being notified of the wound culture results. An observation on 3/11/20 at 9:02 AM revealed an open, reddened are to Resident #111 ' s inner left hand lateral palm at the thumb. Appeared excoriated. An interview with the Treatment Nurse at the time of the observation revealed the resident had contractures to both her hands and the area would appear, get better and reappear off and on. An interview was conducted on 3/12/19 at 9:35 AM with the Infection Control Nurse. She stated she was responsible for receiving and reporting lab results Monday through Friday and she did receive the results of the wound culture on 1/13/20 and handed them to the nurse practitioner. She stated on the weekends, the laboratory drops the results into PCC (the electronic health record) and the floor nurse responsible for the resident was responsible for receiving and reporting abnormal results. She stated the nurse wouldn ' t have to call the on-call nurse practitioner on the weekend if the resident wasn ' t running a fever. An interview was conducted on 3/12/19 at 10:52 AM with Nurse #3 who revealed she was working the day shift on 1/11/20 but was not aware there was a wound culture report pending for Resident #111. She stated the laboratory dropped the results into PCC but the system didn ' t alert her to it. She stated she would have had to know there were results pending and she wasn ' t notified. She stated if she had gotten the results, she would have called the nurse practitioner or physician on call and placed the resident on contact precautions. Nurse #3 stated Resident #111 wasn ' t febrile and showed no signs of infection. A follow up interview was conducted with the treatment nurse on 3/12/20 at 11:07 AM. She stated while she was completing the treatment for [REDACTED]. She stated she put a note in the nurse practitioner ' s book to let her know what she did. She stated she wouldn ' t have told the nurse on the floor providing care to Resident #111 that a wound culture was pending, just the physician or nurse practitioner. An interview was conducted on 3/12/20 at 12:22 PM with the nurse practitioner. She revealed she did see the culture result on 1/13/20 and assessed Resident #111 ' s wound on 1/14/20. She stated at that time, she saw nothing unremarkable and decided to obtain a CBC to further assess for infection. She stated she saw the wound again on 1/16/20 and the appearance was a little different, so she went ahead and ordered the antibiotic therapy. She stated the results of the wound culture should have been called to the on call nurse practitioner on 1/11/20 when they were received by the facility.
F 0584 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to maintain clean floors in 1 of 6 hallways (100 hall) and failed to maintain clean exterior exit doorways for 3 of 6 halls (100, 400 and 600 hallways). The findings included: An observation on 3/9/20 at 12:09 PM revealed multiple areas of what appeared to be dried spills or other substances on the 100-hall floor. Dark build-up was observed in most of the resident room door thresholds, especially heavy and noticeable in rooms 117, 123 and 125. Dark build up was also heavy on the floor from the 100 hall toward the 200 hall. An observation on 3/10/20 at 9:19 AM revealed multiple areas of what appeared to be dried spills or other substances on the 100-hall floor. Dark build-up was observed in most of the resident room door thresholds, especially heavy and noticeable in rooms 117, 123 and 125. Dark build up was also heavy on the floor from the 100 hall toward the 200 hall. An observation on 3/11/20 at 10:05 AM revealed Housekeeper #1 mopping the floor of the 100 hall from the end of the nurses station to room [ROOM NUMBER]. After mopping, the floor remained with the same areas of what appeared to be dried spills or other substances. Dark build up remained in the resident room thresholds. On 3/11/20 at 10:09 AM, an interview was conducted with the Housekeeping Director Assistant. She stated each housekeeper was responsible for the floors in the hallways of their room assignment. She stated there were many areas that could not be removed with mopping and the floor will need a top scrub which would remove the areas or a full stripping and waxing. She stated she did not have a schedule of when the floors were to be scrubbed or stripped and waxed but it was done every 6-7 months. She stated the facility just started stripping and waxing the facility hallways on 3/9/20. She stated they had a floor technician that buffed the floors every day. An observation on 3/11/20 at 11:00 AM revealed the floor technician buffing the hallway outside rooms 105-120. After the buffing was completed, the floors appeared shinier, but areas of dried spills and substances remained as well as darkened areas of resident room thresholds. On 3/11/20 at 11:15 AM, an interview was conducted with the floor technician. He stated he had only been working at the facility for about a month and half and that he didn ' t buff all the floors every day. He stated when he began working, there wasn ' t a schedule for cleaning and buffing the floors, so he made his own. He consulted the schedule and stated he hadn ' t buffed the floors on the 100 hall since 2/25/20. He stated there was a crew that started stripping and waxing the floors at night that began on 3/9/20. An observation on 3/12/20 at 2:00 PM of the exterior exit door on the 600 hall revealed the door was covered with cobwebs and debris. At 2:08 PM, the exterior door of the 400 hall was observed revealing it also was covered with multiple cobwebs. On 2:13 PM, the exterior door of the 100 hall was observed revealing it was also covered with cobwebs and debris. A follow up interview with the Housekeeping Director Assistant on 3/12/20 at 2:30 PM revealed each housekeeper was responsible for cleaning the exterior exit doors in their assigned areas. She stated they should be getting cleaned when they are dirty. She stated she or the Housekeeping Director train new housekeepers on what they are responsible for cleaning. An interview on 3/12/20 at 2:35 PM with Housekeeper #1 revealed she was new to the facility and wanted to clean the exterior exit doors but had not been told she was responsible for doing so. An interview was conducted on 3/12/20 at 3:02 PM with the Administrator. She stated they have a different company that took over providing the chemicals for floor stripping and waxing and the staff was just inserviced and they began stripping and waxing the floors this week.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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

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

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Based on observations, record review, staff and nurse practitioner interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of 1. Active [DIAGNOSES REDACTED].#111) reviewed for pressure ulcers and, 2. Falls for 1 of 2 residents (Resident #6) reviewed for falls. The findings included: 1. Resident #111 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the quarterly MDS assessment dated [DATE] indicated Resident #111 had an active [DIAGNOSES REDACTED]. Wound infection was not coded on the assessment. An observation on 3/11/20 at 9:02 AM revealed an open, reddened are to Resident #111 ' s inner left hand lateral palm at the thumb. Appeared excoriated. An interview with the Treatment Nurse at the time of the observation revealed the resident had contractures to both her hands and the area would appear, get better and reappear off and on. She stated in January it showed signs of infection and she obtained a wound culture and it did show [MEDICAL CONDITION]. She stated the Nurse Practitioner assessed the area and decided it should be treated and Resident #111 was placed on antibiotic therapy. A record review revealed a lab report dated 1/11/20 of a wound culture obtained on 1/7/20 from Resident #111 ' s left inner hand at thumb was positive for [MEDICAL CONDITION]. A record review of a progress note by the Nurse Practitioner dated 1/16/20 revealed Resident #111 ' s wound to her left hand at the thumb was exhibiting purulent drainage and antibiotic therapy was initiated. A physician's order [REDACTED]. A review of the January Medication Administration Record [REDACTED]. An interview was conducted on 3/12/20 at 2:34 PM with the MDS coordinator. She revealed she saw where Resident #111 was coded [MEDICAL CONDITION] but the wound infection did not get coded. 2. Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of falls for Resident #6 did not indicate she sustained a fall with major injury during the assessments look back period. An interview was conducted on 3/12/20 at 2:34 PM with the MDS coordinator. She stated Resident #6 had a fall with major injury in November of 2018 and the MDS dated [DATE] was coded in error.
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident assessment for a Level II PASRR (Preadmission Screening and Resident Review) was completed for 1 of 1 sampled resident (Resident #9) reviewed for Level II PASRR. Findings included: Review of Resident #9 ' s Annual Minimum Data Set ((MDS) dated [DATE] revealed that Resident #9 had been admitted to the facility on [DATE] and presently had [DIAGNOSES REDACTED]. Review of the PASRR Level I Determination Notification letter dated 7/03/18 revealed that No further PASRR screening is required unless a significant occurs with the individual ' s status which suggests a [DIAGNOSES REDACTED]. Review of Resident #9 ' s medical record revealed a new [DIAGNOSES REDACTED]. In an interview on 3/11/20 at 11:23 AM Social Worker #1 stated usually the Admission Coordinator records the data in the system and she had been out on leave. Social Worker #1 expressed having no knowledge of Resident #9 ' s evaluation for a Level II PASRR. In an interview on 3/11/20 at 11:30 AM Social Worker #2 explained there was coordination between Admission Coordinator, MDS Nurse, and Social Work for PASRR processing. She stated Resident #9 may have been missed during the process since the Admission Coordinator had been absence. Social Worker #2 explained there was no record of a Level II PASRR filed for Resident #9 with his added [DIAGNOSES REDACTED]. In an interview on 3/11/20 at 11:40 AM MDS Nurse #1 expressed she entered data on the annual MDS assessment and the [DIAGNOSES REDACTED].#9. In an interview on 3/11/20 at 12:30 PM the Administrator stated the staff missed the submission for the Level II PASRR and the facility would be addressing the missed evaluation immediately.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and nurse practitioner interviews, the facility failed to 1. obtain a physician ordered lab test for 1 of 2 residents (Resident #111) reviewed for pressure ulcers and, 2. Failed to correctly transcribe a prn (as needed) [MEDICAL CONDITION] medication order from a written telephone order to the electronic health record (EHR) for 1 of 5 residents (Resident #26) reviewed for unnecessary medications. The findings included: 1. Resident #111 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A record review revealed a laboratory culture report dated 1/11/20 from a wound culture of Resident #111 ' s left hand at the thumb that was collected on 1/7/20. The wound culture showed [MEDICAL CONDITION] (MRSA). A record review revealed a physician's order [REDACTED].#111. There was no evidence in the chart that a CBC was collected until 2/5/20. The nurse practitioner ' s progress note dated 1/16/20 revealed Resident #111 was seen for acute on chronic wound on thumb/hand. An aerobic bacterial culture showed heavy growth of Staphylococcus aureus [MEDICAL CONDITION] resistant. The note further indicated the nurse practitioner saw the resident on 1/14/20 and the wound looked unremarkable and the wound nurse affirmed wound was no longer draining and as red as before, even the swelling had gone down. CBC (complete blood count) ordered for 1/15/20. Today, purulent drainage noted in the wound. [MEDICATION NAME], antibiotic, with [MEDICATION NAME] and wound consult initiated. An interview was conducted on 3/12/19 at 9:35 AM with the Infection Control Nurse. She stated she was responsible for receiving and reporting lab results Monday through Friday and on the weekends, the laboratory drops the results into PCC (the electronic health record) and the floor nurse responsible for the resident was responsible for receiving and reporting abnormal results. She stated she received results of the wound culture that was obtained on 1/7/20 and gave them to the nurse practitioner on Monday, 1/13/20 who wanted to obtain a CBC to see if Resident #111 ' s white blood count was elevated before deciding to place the resident on an antibiotic. The Infection Control Nurse reported back to the surveyor at 9:45 AM that the CBC would have been collected on Resident #111 ' s next lab day. An interview was conducted on 3/12/20 at 9:53 AM with the Restorative Nurse who revealed the lab technician comes to the facility every day to draw and collect labs. An interview was conducted on 3/12/20 at 12:22 PM with the nurse practitioner. She revealed she received results of a wound culture obtained from Resident #111 ' s left hand on Monday, 1/13/20 and assessed Resident #111 ' s wound on 1/14/20. She stated at that time, she saw nothing unremarkable and decided to obtain a CBC to further assess for infection. The order was written on 1/14/20 to obtain the CBC on the next lab day and she expected the CBC to be collected the next day and didn ' t know why it wasn ' t collected. 2. Resident #26 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #26 was cognitively intact. He received anti-anxiety medication for seven of seven days of the look back period. A care plan problem updated 1/10/20 included anxiety. A care plan intervention stated, give medication as prescribed by physician. A telephone physician order [REDACTED].#26's hard chart stated, Klonopin (an anti-anxiety medication), 0.5 milligrams (mg) every evening prn anxiety times 14 days-no refills. An order in the EHR dated 2/17/20 revealed, Klonopin, 0.5mg, give by mouth every 24 hours as needed for anxiety at bedtime only. There was no end date or duration listed on the order in the EHR. The February Medication Administration Record [REDACTED]. The March MAR indicated [REDACTED]. On 3/12/20 at 9:50 AM an interview was completed with Resident #26. He said he took Klonopin twice a day routinely and also had an order for [REDACTED]. During an interview with Nurse #1 on 3/11/20 at 2:28 PM, she explained that Resident #26 requested Klonopin daily and told staff if he felt nervous or anxious. An interview was completed with Nurse #2 on 3/12/20 at 8:58 AM. She stated nurses entered the handwritten telephone orders into the EHR. She recalled she was in orientation with Nurse #1 when the telephone order was written for prn Klonopin and she entered it into the EHR as routine and the nurse who she was orienting with had corrected the order so that it reflected prn. On 3/12/20 at 9:06 AM a follow up interview was completed with Nurse #1 during which she said nurses entered the handwritten telephone orders into the EHR. She explained the prn Klonopin order was not correctly entered into the EHR. Nurse #1 added she had not overseen Nurse #2 and had not made any corrections to the order and stated, She (Nurse #2) must have taken it upon herself to enter it in. She must have forgot to put the duration in. An interview with the Administrator on 3/12/20 at 9:26 AM revealed when a telephone order was received the nurse entered it into the EHR. She explained the nurse who entered the order in the EHR was new and listed the end date as indefinite. The Administrator added that typically the nurse who received the order for a prn [MEDICAL CONDITION] entered it into the computer with a 14 day stop date. She confirmed that the 14 day stop date should have been 3/1/20.
F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews and medical record review, the facility failed to obtain podiatry services for 1 of 1 resident (Resident #130) reviewed for foot care. Findings included: Resident #130 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #130

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F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) had moderately impaired cognition. She required extensive assistance with her personal hygiene. A care plan updated 2/26/20 included a problem related to activities of daily living/personal care. An intervention included, provide extensive physical assistance with personal hygiene/grooming. On [DATE] at 12:51 PM an observation of Resident #130's feet revealed long and thick toenails on both feet. Resident #130's medical record was reviewed and revealed the resident representative signed consent on 7/23/19 for the resident to be seen by the podiatrist. Further review indicated Resident #130 had not been seen by a podiatrist since her admission. An interview was completed with Social Worker (SW) #1 on 3/11/20 at 8:53 AM. She stated a podiatry service came to the facility approximately every 2-3 months and saw about 40 residents at each visit. She explained when a resident was admitted to the facility the resident representative signed a waiver that gave permission for the resident to be seen by the podiatrist. The facility sent the signed waiver to the podiatry service and then the podiatrist sent a consent form to the resident's primary care physician for authorization. SW #1 added that all residents were on the list for podiatry services. She said the podiatrist was scheduled again at the facility on 4/9/20 and provided a list of residents who were scheduled to be seen at that time. Resident #130 was not on the list. SW#1 reviewed the podiatry list from 7/23/19 to 3/11/20 and reported, I don't see that she's been on the list to be seen. During an interview with Nurse #4 on 3/11/20 at 9:08 AM she explained that if a resident or family member told her they needed to see the podiatrist then she told the SW. Nursing also notified the SW of podiatry needs if the nurse or aide noticed a resident's toe nails were too long when they provided care. An observation of Resident #130's toenails was completed with Nurse #4 after the interview and the nurse described the resident's toenails as long and thick and stated, she would be someone who would need to be seen by the podiatrist. An interview was completed with Resident #130 during the observation and she said her toenails did not hurt and were not uncomfortable. The Director of Nursing (DON) was interviewed on 3/11/20 at 9:20 AM. During the interview, an observation was made with the DON of Resident #130's feet. The DON expressed that the resident's toenails were long and thick and said Resident #130 was probably on the list to be seen by podiatry. She explained that both nurse aides and nurses were able to cut fingernails and toenails of residents. The DON said that based on her observation of Resident #130's feet, she needed to be seen by the podiatrist. On 3/12/20 at 9:36 AM an interview was completed with the Administrator. She stated the podiatrist had only been in the facility twice since July 2019 and was scheduled again for April 2020. She added the podiatrist only saw 40 residents at a time. A follow up interview was completed with SW #1 on 3/12/20 at 10:21 AM. She provided a list of dates that the podiatrist had been in the building since July 2019 which included 9/18/19, 11/1/19, 11/7/19, 1/5/20, and 2/10/20. SW#1 said she had talked to the podiatry service provider and discovered that after the service received the signed consent form from the resident representative, they had not sent an order to the facility physician for signature.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Observe each nurse aide's job performance and give regular training.** Based on record review and staff interview, the facility failed to ensure Nursing Assistants (NA's) received annual Dementia and Abuse/Neglect training. This was for 1 of 5 NA's reviewed for staffing. The findings included: Facility personnel file review was conducted on 3/12/2020 at 1:15 pm of five randomly picked clinical staff members. Investigation revealed that NA #1 was due for annual Dementia and Abuse/Neglect training on 10/23/2019 and received no in-service training for the 2019 calendar year. An interview was conducted with the Staff Development Coordinator (SDC) on 3/12/2020 at 1:15 pm who advised that she had hired into that role in November 2019 and, as far as she knew, there had not been anyone in the SDC role for almost a year prior. She stated that she was currently working on making sure all employees received the required training for their individual jobs. During an interview on 3/12/2020 at 1:30 pm, the Director of Nursing (DON) stated that there was someone in the SDC role last year but that she was terminated about three months prior to the current SDC being hired. The DON revealed that she was terminated near the end of September because the facility felt like she wasn't doing her job properly. Therefore, the facility had gone a few months without an SDC. During an interview on 3/12/2020 at 3:10 pm, the Administrator was advised of the lack of annual training and she stated when the previous SDC left last fall, the task of ensuring staff training did not get completed as expected. She felt confident that the situation would resolve with the current SDC in place.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to safely and securely store medications observed to be left at the bedside for 1 of 32 sampled residents (Resident # 138) reviewed. The findings included: Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On [DATE] at 10:55 AM an observation was made of Resident #138 lying in her bed. On the nightstand beside Resident #138 ' s bed was a 1-ounce plastic medicine cup with a dime sized pink tablet inside it. A record review revealed an order for [REDACTED].#138 did not have an order to self-administer medications. The record review further revealed no assessment for self-administering medications. An interview was conducted on [DATE] at 11:00 with Nurse #3. She stated she was assigned to Resident #138 and administered her medications that morning. She stated the pink tablet was a tums and should not be at the bedside. She stated she should have already taken that.