STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345050	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jacob's Creek Nursing and Rehabilitation Center	1721 Bald Hill Loop Madison, NC 27025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33778 Based on observations, record review, and resident, physician, nurse practitioner and staff interviews the facility failed to protect a resident's right to be free from physical abuse. Resident #123 was observed sitting on a black container behind Resident #100 with his left hand around Resident 100's neck and his right arm covered around his left arm. Resident #100 was leaning forward and crying, and her face was blue. Resident #100 continued to cry after the residents were separated. A skin assessment completed after the incident revealed Resident #100 had redness on her cheeks and petechiae (tiny spots of bleeding under the skin) on the front part of her neck. The abuse occurred for 1 of 3 sampled residents reviewed for protection from abuse (Resident #100). The findings included: Resident #123 was admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease, major depressive disorder, post-traumatic stress disorder (PTSD), dementia with psychotic disturbance, conduct disorder and generalized anxiety disorder. Review of his significant change Minimum Data Set (MDS) assessment, dated 5/29/24, revealed that he was severely cognitively impaired and required supervision with activities of daily living (ADL). The resident was ambulatory with combative and aggressive behavior toward residents and staff. Resident #123 received antidepressant, antianxiety and anticonvulsant medications. Review of physician's orders for Resident #123 for August 2024, revealed that he received psychotropic medications. Review of the Medication Administration Record (MAR) for August 2024 revealed that the MAR reflected physician's orders and was completed. Resident #123 received scheduled and as needed psychotropic medications. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the care plan for Resident #123, revised on 5/29/24, revealed he had declined in intellectual functioning, expressing emotion, understanding information, characterized by ineffective coping, disorganized thinking, verbal and physical aggression or agitated, combativeness towards staff members and wandering. Resident #123 received psychotropic medications. The interventions including to ensure safety for residents and staff, monitor and document behavior, attempt to redirect resident, allow adequate time to complete tasks, remove resident from public area when behavior is disruptive or unacceptable, observe and report changes in cognitive status, provide the psychiatric consultation as needed, and medication treatment per order. Resident #100 was admitted to the facility on [DATE]. Her diagnoses included dementia, bipolar disorder and Alzheimer's disease. Review of her quarterly MDS assessment, dated 7/17/24, revealed that she was severely cognitively impaired and required limited assistance with ADL. Resident #100 received psychotropic medications. She was ambulatory with wandering, refusal and non-cooperative behavior. Review of the care plan for Resident #100, revised on 7/17/24, revealed she had an ineffective coping, judgment, decision making, deficit in memory and thought process, verbal and physical aggression or agitated, combativeness towards staff members and wandering. The interventions including to ensure safety for residents and staff, monitor and document behavior, attempt to redirect resident, allow adequate time to complete tasks, remove resident from public area when behavior is disruptive or unacceptable, observe and report changes in cognitive status, provide the psychiatric consultation as needed, and medication treatment per order. Nurse #1's witness statement, dated 8/1/24, indicated on 8/1/24 at 5:15 PM, Resident #123 was sitting on the black container in front of the closet. Resident #100 was standing leaning forward in front of the closet between the container and the closet. Resident #100 was leaned over his left knee. Resident #123 had his left arm around Resident #100's neck and his right arm wrapped around his left arm. Resident #100's face was blue. I pulled [Resident #123's] arms apart. [Resident #100] stood up and started walking. I took/directed [Resident #100] up the hall. [Resident #100] was crying. [Resident #100's] face/cheeks petechiae/red. Front of neck red. Another nurse (Nurse #2) stayed with Resident #123. [Nurse #2] directed Resident #123 to his room and was given as needed Ativan IM (intramuscular). Resident #123 was shaking after the interaction but was calm at present. On 9/4/24 at 3:45 PM Nurse #1 indicated during an interview she was assigned to Residents #123 and #100 on second shift on 8/1/24. At approximately 5:00 PM, she heard a crying noise from an empty resident room. Nurse #1 went to the room with Nurse #2 and observed two residents. Resident #123 was sitting on the small plastic container and Resident #100 standing, leaning forward in front of him. Resident 123's arms were around Resident 100's shoulder and neck and she was crying. Nurse #1 stated both nurses pulled Resident 123's arms away from Resident #100's neck. Nurse #1 redirected Resident #100 to the hallway and left Nurse #2 with Resident #123. Upon assessment, Resident #100 had a small area of redness on the front part of her neck and her cheeks. When Nurse #1 asked Resident #123 what he was doing, the resident stated that he tried to take his motorcycle to the house. Nurse #1 reported the incident to the administration, completed the incident report, provided the written witness statement, placed Resident #123 on 1:1 monitoring, while Nurse #2 remained with Resident #100 near the nurses' station. Resident #100 stopped crying in about 10-15 minutes. Nurse #1 mentioned prior to the incident, both residents wear at the baseline behavior during the shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/15/24 at 7:00 PM, during the phone interview, Nurse #1 recalled that on 8/1/24, she observed Resident #123 with his left arm around Resident 100's neck and his right arm covered around his left arm. Resident #100 was breathing, crying, and her face turned blue. Nurse #1 removed Resident 123's arms from Resident #100 and separated both residents. Nurse #1 took Resident #100 to the nurses' station, where she was able to drink water and stopped crying within 10 minutes. Nurse #1 took vital signs, which were within normal limit. Nurse #2's witness statement, dated 8/1/24, indicated at 5:15 PM Nurse #2 heard a crying noise and she and another nurse (Nurse #1) went in room [ROOM NUMBER] (empty resident room). [Resident #100] was bent over near the closet and Resident #123 was sitting on a three tier drawer. [Resident #100] leaned beside him between the drawer and closet. [Resident #100] had his left arm wrapped around [Resident #100's] neck. We pulled [Resident #123's] arm away from [Resident #100's] neck. [Resident #100's] helmet was on the floor in front of her. Another nurse stayed with [Resident #100]. I stayed with [Resident #123]. [Resident #123] was visibly shaken. Resident #123 stated, She stole my money. [Resident #123] walked and sat in a chair and slowly calmed down over ten minutes. Nurse Aide walked Resident #123 to his room. 1:1 monitoring continues. During an interview on 9/4/24 at 3:55 PM, Nurse #2 indicated on 8/1/24 at 5:15 PM she heard a crying noise and, together with Nurse #1, entered an empty resident room and found Resident #123 sitting on a small container, with his left hand around Resident 100's neck and the right hand on her shoulder. Resident #100 was in front of him leaning forward and crying. They separated the residents and assessed both residents. Resident #123 did not have skin issues and stated he tried to get back his motorcycle. Resident #100 had some redness on her cheeks and petechiae (tiny spots of bleeding under the skin) on the front part of her neck. Resident #100 remained near the nurses' station and stopped crying in ten minutes. The resident did not say anything after the incident. Nurse #2 stated when she asked Resident #123 what he was doing, the resident replied he tried to take his motorcycle to the house. On 9/16/24 at 9:20 AM, during the phone interview, Nurse #2 indicated that on 8/1/24, she observed Resident #123 was sitting and Resident #100 was staying, bending forward. Resident 123's left arm was around Resident 100's neck, his right arm reached his left arm. Resident #100 was crying, and her face was purplish. Nurses pulled Resident 123's arms away from Resident 100's neck. Nurse #1 took Resident #100 to the nurses' station and Nurse #2 remained with Resident #123. Nurse #2 mentioned that prior to the incident, both residents were at the baseline behavior, walked on the hallway and did not have signs of possible behavior escalation. Review of the Medication Administration Records (MAR) for August 2024 revealed Resident #123 received as needed Ativan 0.5 ml injection on 8/1/24 at 4:30 PM. Nurse Aide #1's witness statement, dated 8/1/24, indicated about ten minutes after the incident on 8/1/24 she observed Resident #100 sitting at the nurses' station. The resident had a red face. Prior to the incident, Nurse Aide #1 provided incontinence care for Resident #100, and she did not show behavior issues. Approximately thirty minutes prior to the incident, Nurse Aide #1 observed Resident #123 was calm, walked on the hallway and talked about [NAME] House and food in pleasant happy mood. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 9/5/24 at 4:00 PM Nurse Aide #1 indicated that on 8/1/24 she was assigned to Residents #123 and #100 on second shift. At 4:30 PM, she provided incontinence care for the Resident #100 and did not observe behavior problems. At approximately 5:00 PM, Nurse Aide #1 observed Resident #123 walking on the hallway, talking loudly, which was his routine behavior. Nurse Aide #1 did not witness the incident between Resident #123 and Resident #100, but right after the incident, she observed Resident #100 near the nurses' station with Nurse #1. Resident #100 did not cry, appeared calm and quiet. Record review of the skin assessment completed by Nurse #1 on 8/1/24, indicated that Resident #100 had petechiae to the front of the neck and redness on her face. Record review of the skin assessment, conducted by Nurse #2 on 8/1/24, indicated that Resident #123 had no skin issues. The Assistant Director of Nursing's (ADON) witness statement dated 8/1/24 indicated that after the incident, when she asked Resident #100 if anyone hurt you, the resident replied No. Record review of Psychiatrist's visit dated 8/5/24, revealed that Resident #123 was referred for dementia and aggressive physical behavior. He had a history of disturbing behavior and was oriented in person only during the assessment. After consulting with staff and nursing managers, a collaborative decision had been made to increase the dosage of psychotropic medications to reduce agitation and combativeness toward staff and other residents. Record review of Psychiatrist's visit, dated 8/5/24, revealed that Resident #100 appeared in no acute distress, with delusional ideations and no new psychiatric complaints. She was compliant with current psychotropic treatment and psychotherapy. On 9/4/24 at 9:15 AM, a phone interview with the Psychiatrist revealed he was aware of the incident between Resident #123 and #100 on 8/1/24. Both residents were diagnosed with psychiatric diseases, received psychotropic medications and psychiatric service. They tolerated it well. The Psychiatrist visited Resident #123 and #100 on 8/5/24. He continued that the staff handled the incident very well, provided 1 on 1 monitoring, redirection, notification and medications. The Psychiatrist stated he adjusted the psychotropic medication regimen for Resident #123, and there were no behavior related issues reported so far. Resident #100 also received close monitoring, was a fall risk and used the helmet for fall precautions. The interview further revealed both residents received appropriate care in the locked unit, which was discussed with the nursing management and resident's family. Record review of the Investigation Report, dated 8/7/24, indicated that on 8/1/24 at 5:15 PM, Resident #123 was observed by the nurses sitting on the three tier drawers in an empty resident room and had his arms on Resident 100's shoulders, around her neck, while she was standing, leaning forward in front of him. Resident # 100 was crying. Upon assessment, she had a reddened area on her cheek and front part of the neck. The report recorded that both residents were separated and the Medical Director, Responsible Party, Law Enforcement and Adult Protective Services (APS), were notified of the incident. On 9/3/24 at 2:05 PM, during the observation/interview, Resident #100 was sitting in her room and watching TV. She had a helmet on her head. The resident did not recall the incident. (continued on next page)

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	345050	A. Building B. Wing	09/18/2024

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/3/24 at 2:25 AM, during the observation/interview, Resident #123 was in his room. He was calm and did not answer questions. There were no staff members in his room. On 9/4/24 at 2:15 PM, during an interview, the Medical Director indicated that he was aware of the incident between Residents #123 and #100 in the locked memory unit on 8/1/24. Both residents had diagnoses of Alzheimer's disease and dementia with severely impaired cognition and received psychotropic medications. Both residents were followed by mental health services for a history of behavior, and when this occurred, were referred for psychiatric services. After the incident, Resident #123 received psychiatric consultation in the facility with effective adjustment of the psychotropic medication regimen. The nursing staff gradually replaced the 1:1 monitoring with 15-minute visual checks. The facility put ongoing monitoring into place for both residents and Resident #100's responsible party agreed with the current plan of care and treatment. The Medical Director stated that the facility had a responsibility to protect all residents in the facility and due to the facility's high-risk population of residents with a mental health/behavior history, that made managing behaviors difficult. The administration and nursing staff met the mental health needs of the residents by making mental health services readily available. On 8/27/24, Resident #123 became verbally, physically aggressive toward staff and was sent to the psychiatric hospital. Upon return from the hospital, the resident remained calm, quiet and did not require 1:1 monitoring. On 9/5/24 at 4:35 PM, during an interview, the Director of Nursing (DON) indicated staff reported to her on 8/1/24 that Resident #123 had his arms around the Resident #100's neck and shoulders, which resulted in Resident #100's redness on her cheeks and petechia on the neck. Resident #123 did not have injuries. Both residents were diagnosed with psychiatric diseases, received psychotropic medications and psychiatric services. The residents were separated immediately, and Resident #123 was placed on 1:1 monitoring. He received a psychiatric evaluation and medication treatment adjustment. The staff received education on resident-to-resident abuse and the behavior tool audit was conducted for other residents. Both residents returned to the baseline within a few hours after the incident, could not recall the incident, and Resident 100's skin was normal in a few days. DON discussed the incident with Resident #100's responsible party, who verbalized understanding and appreciated the interventions. The DON was notified of immediate jeopardy on 9/16/24 at 10:18 AM. The facility implemented the following Corrective Action Plan with a completion date of 8/5/24. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #123 is alert but not oriented to person and place with a Brief Interview for Mental Status (BIMs) of 1. Diagnoses include Alzheimer's dementia, post-traumatic stress disorder, recurrent major depressive disorder, anxiety, conduct disorder, and adjustment disorder. Resident #100 is alert but not oriented to person and place with a BIMs of 2. Diagnoses include severe dementia and bipolar disorder. Both residents reside in the memory care unit. On 8/1/24 at 5:00 pm, after hearing crying, memory care Nurse #1 and Nurse #2 walked into a room not belonging to the involved residents and observed Resident #123 sitting on a black container in front of the closet, with his left arm around Resident #100 face and neck and his right arm was wrapped around his left arm. Nurse #1 guided Resident #123's arm from Resident #100 neck and separated the two residents. Nurse #2 remained with Resident #123, who was placed on 1:1 monitoring immediately after the incident. Resident #100 was assessed immediately by memory care Nurse #1 and noted to be crying, and her face was blue. Additionally, Nurse #1 observed petechia (pinpoint, round spots that form on the skin, caused by bleeding, which makes the spots look red, brown or purple) on Resident #100 face and cheeks. Resident #100 was taken to the nurses' station and placed on 15-minute checks by Nurse #1. Approximately 5 minutes later, Resident #100 had calmed down and was noted to be no longer crying by Nurse #1 and Nursing Assistant (NA) #1. Resident #123 stated that he reached out to get his motorcycle and was trying to make it back from his house. Resident #100 could not verbalize what happened during the incident due to impaired cognition. Nurse #1 administered Ativan 0.5 milligrams (mg) Intramuscular to Resident #123. The Assistant Director of Nursing and Unit Manager notified the physician and resident representatives of the incident. Resident #100 had no long term affects from the incident. Resident #100 remained on every 15-minute checks for 24 hours after the event with no negative findings observed. On 8/2/24, the Social Worker completed a wellness visit with resident #100 with no negative findings. On 8/5/24, Resident #100 was seen by the psych Nurse Practitioner with no new orders. On 8/16/24, after review of the resident's behaviors in the Interdisciplinary meeting, the interdisciplinary team (Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Worker, Activities Director, Minimum Data Set Nurses, and Therapy) made the decision to decrease Resident #123's supervision to 15-minute checks every 1st and 3rd shifts and remain on 1:1 on 2nd shift. On 8/19/24, Resident #123 was seen by psych services with no new orders. On 8/22/24, another review of Resident #123 behavior was completed by the Interdisciplinary team (Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Worker, Activities Director, Minimum Data Set Nurses, and Therapy). The resident had not had any further behaviors, therefore the interdisciplinary team decided to decrease Resident #123 supervision to every 15-minute checks on all shifts. On 8/27/24, Resident #123 was admitted to a behavior health treatment center per the Nurse Practitioner's orders related to combativeness with staff. The resident representative, who was on site at the facility, was notified and in agreement of Resident #123 being transferred to the behavior health treatment center. The resident's psych medications were adjusted during the stay. On 8/30/24, upon return to the facility, the every 15-minute checks for Resident #123 were removed. How will the facility identify other residents having the potential to be affected by the same deficient practice? On 8/1/24, skin assessments were completed on all residents in the memory care unit for signs and symptoms of abuse by the Unit Manager with no negative findings. No residents in the memory care unit are alert and oriented for interview. (continued on next page)

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	345050	A. Building B. Wing	09/18/2024

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/2/24, 100% of resident's progress notes and behavior alerts in the electronic records were audited by the Assistant Director of Nursing (ADON) to identify any behaviors that occurred in the last 14 days to ensure interventions were in place to prevent escalation of behaviors that may lead to resident to resident altercations/abuse and to ensure the behaviors and interventions were addressed on the resident's care plan. The audit was completed on 8/2/24. No concerns were identified during the audit. On 8/2/24, the ADON reviewed incident reports related to resident to resident altercations for the past 30 days to identify patterns and trends. No trends were identified during the audit. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? On 8/2/24, an in-service was initiated by the Assistant Director of Nursing (ADON) with all facility staff regarding recognizing and de-escalating resident behaviors that may lead to resident to resident altercations. The facility does not utilize agency staff. The in-service emphasized the implementation of early interventions to address behaviors and reporting behaviors to prevent escalation of behaviors that may lead to resident-to-resident altercation/abuse. The in-service was completed with all staff that worked for the period of 8/2/24 through 8/4/24. After 8/4/24, the Assistant Director of Nursing monitored staff completion, and any staff that had not worked and had not completed the in-service would complete the in-service prior to taking an assignment on their next scheduled shift. All newly hired staff will be educated during orientation by the Nurse Managers regarding de-escalating resident behaviors/prevention of resident to resident altercation/abuse. The Administrator discussed this responsibility with the Nurse Managers on 8/2/24. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? On 8/1/24, a Performance Improvement Plan was developed for prevention of resident to resident altercations/abuse and approved by the Quality Assurance Performance Improvement team (QAPI). The Unit Managers will review progress notes and behavior alerts 3 times per week x 8 weeks then monthly x 1 month to identify residents with behaviors utilizing the Behavior Audit Tool This audit is to ensure all behaviors are being addressed with an early intervention, physician and resident representative notification, and addressed on the care plan to prevent escalation of behaviors that may lead to resident-to-resident altercations/abuse. The Unit Manager will address all concerns identified during the audit. The Director of Nursing or Assistant Director of Nursing will review the Behavior Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately. The Administrator or Director of Nursing will present the findings of the Behaviors Audit Tools to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months to review and to determine trends and/or issues that may need further interventions and the need for additional monitoring. On 8/1/24, the prevention of resident to resident altercations/abuse was taken to QA by the Administrator. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Corrective Action plan was validated onsite on 9/18/24 when staff interviews revealed they had recently received education on Abuse, including Recognizing and De-escalating Resident Behaviors that Lead to Resident to Resident Altercations. In-service reports and sign-in sheets were used to verify this information. Skin Assessments on all residents in the Dementia Unit were completed and reviewed with no new skin issues found. Behavior Audit tools were completed by the Unit Managers and reviewed by the Interdisciplinary Team (IDT), daily. Resident #123's behavioral monitoring was discussed daily from 8/5/24 through 8/27/24. The facility's completion date of 8/5/24 for the Plan of Correction was validated on 9/18/24