STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258 SS=E	483.10(i)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS (i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility failed to maintain comfortable sound levels throughout the building and on all shifts for 3 of 9 sampled residents who were interviewed and did not have hearing impairment (#34, #49 and #21). Findings included: On 5/22/17 at 9:46 AM, after resident #34 was asked whether she had any problem with the temperature, lighting, noise or anything else that affects her comfort, she stated, "Sometimes, the noise up front (200 day room) is loud." She added the noise comes from the staff from 6:00 PM to 10:00 PM. The floor cleaning machine was noted be very loud on day shift on 5/22/17. TVs were on loudly at all hours of the day and night. Observations were made on 5/23/2017 at 2:24 AM. Many residents had lights on, TVs on and doors open. Some residents were awake and some were asleep. TVs were on in rooms 201, 202, 205, 215 and 217 and the residents were asleep. The TV was on and the sound was turned up very loudly in the family room across from the 300/400 hall nurses' station on 05/23/2017 at 5:33 AM, even though no one was in the room. Interview with the Floor Technician on 5/23/17 at 10:30 AM revealed he agreed the floor machine was loud. Interview on 5/24/2017 at 8:04 AM with RN #2 who works the night shift revealed, "It is noisy.	F 258	PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE ADMISSION BY THE PROVIDER OF THE TRUTH OF FACTS ALLEGED OR THE CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSEIT IS REQUIRED BY THE PROVISIONS OF THE FEDERAL AND STATE LAW. F258 For the residents cited: Resident #34's room is located on the 400 hall, DNS completed a training with the staff on being mindful of the volume of voices during report and interaction especially between the hours of 6p-10p; Resident #49 the maintenance Director has inspected the wheels on carts (ice, linen, and barrels) to ensure good working order; Ice pass has been moved to 6am to reduce cart noise; Resident #21; maintenance Director contacted outside vendor to check operations of floor machines 6/16/17. Follow-up with Resident #34, #49, and #21 by the facility Administrator resulted with them reporting they have noticed an improvement related	6/21/17

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

Electronically Signed | 06/16/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258	Continued From page 1 Some residents can't hear well and like TV on all night." When RN #2 was asked about the TV on in family room and no one in the room, she said, "We have a resident who stays in there with the TV on for many hours in the evening." She said the call bells are going off all night and the floor machine is loud every day. On 5/24/2017 at 8:33 AM, Resident #49 said it is noisy at night. She attributed the noise to carts rolling down halls and conversations. She added her roommate liked to keep the door open. On 5/24/2017 at 1:39 PM, Resident #21 mentioned the noise in the nursing home. He said the noise was noticeable "when they use the machines on the floor and some have their TVs too loud." He added TVs were loud because some residents were hard of hearing. On 5/24/2017 at 3:48 PM, the Housekeeping Contract Manager was interviewed. He said there were no complaints about the floor machine recently. He added that the Floor Technician must make sure the pad is centered. He changed the pad yesterday after a surveyor said something to him. "If the nut is loose, the pad may need to be realigned. I noticed it was loud too." On 5/24/2017 at 4:25 PM the Corporate Representative said she wasn't aware of any concerns with sound levels.	F 258	to noise levels. For all residents potentially affected: Current residents were interviewed to determine any concerns with current sound levels and identify the source of noise. System Changes: The facility has initiated the following corrective measures to ensure comfortable noise levels; a. Facility Administrator met with the Resident Council on 6/14/17, to discuss resident concerns regarding noise levels. During this meeting, only 1 resident mentioned “sometimes” other resident TV’s are loud, no one else had an issue with uncomfortable noise levels. DNS has completed an in-service with staff about turning down TV’s that are loud. b. Identified floor machine has been evaluated by the outside vendor to check operations of machines 6/16/17. Housekeeping staff have received in-service by Maintenance Director on proper operation of floor machine and immediate notification of any equipment operation problems, including loud noise. c. Residents identified as requesting to sleep with their TV on, have been counseled on the pros and cons of disruptive sleep patterns, and courtesy of allowing staff to turn TV’s off and/or decrease volume, after they are asleep. Care Plans for these residents have been updated to reflect their choices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258	Continued From page 2	F 258	d. Current staff have received in-service by the facility Administrator & DNS regarding, F258 Maintaining Comfortable Sound levels including lowing voices, diming hallway light and turning TV's off in common rooms when residents are not in those rooms, during the evening hours to promote a pleasant rest environment for the residents. Monitoring for compliance: Compliance rounds will be conducted by the QAPI members daily, and interviewing 5 random residents weekly for 4 weeks, than monthly for 6 months, to ensure we are maintaining a comfortable sound level for the residents. Facility Administrator will complete a summary of all monitoring efforts and present to the facility QAPI committee monthly for 3 months, to assure a trend of compliance is evident.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the	F 278		6/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 3 assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for physician prescribed weight loss regimen with significant weight loss, and Preadmission Screening and Resident Review level II for 2 of 20 sampled residents whose assessments were reviewed (#34, #83) Finding include: 1. Resident #83 was admitted on 9/17/14 with the current diagnosis of adult failure to thrive, hypertension and dysphagia. A physician order revealed the resident had a regular diet ordered 3/29/16.	F 278	F278 For the residents cited: Medical record for Resident #83 and #34 were reviewed by the Corporate MDS Consultant, related to PASARR and Swallowing/Nutrition. MDS assessment was modified & transmitted on 6/15/17, to reflect accurate coding of Section A and K. For the residents potentially affected: Corporate MDS Consultant completed an audit of current resident MDS assessment and cross referenced their medical record to ensure MDS coding is accurate, including Section A and K. Any modifications noted have been made and transmitted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 4 A dietary note dated 2/16/17 revealed the resident had significant weight loss change over the most recent 180 days and weighed 146 pounds. The resident continued on a regular diet with snacks at night. The resident had also been receiving supplements and had been accepting all supplements. Another dietary note dated 3/7/17 revealed the resident had significant weight loss for the last 30 days. The resident continued on a regular diet with snacks at night. The resident was receiving supplements and accepting all supplements. The suspected weight loss was due to fair intake by mouth and diuretic use. The resident was noted to have less edema in bilateral lower extremities. A physician order revealed the resident had a nutritional supplement ordered 3/7/17 through 5/17/17. Resident's #83 Quarterly Minimum Data Set (MDS) dated 3/10/17 revealed the resident was severely cognitively impaired. The resident weighed 138 pounds. The MDS stated the resident had significant weight loss and was on a physician prescribed weight loss regimen. MDS nurse #2 was interviewed on 5/24/17 at 1:01 PM. He stated the resident had a significant weight change for the past 30 days but non-significant weight changes for the past 90 days when the MDS dated 3/10/17 was coded. He stated the resident was coded for weight loss. The resident was not on a physician-weight loss diet. The resident was receiving a regular diet with a snack at night. He stated that dietary had coded this section of MDS and that the staff member who coded it did not work there	F 278	System changes: Corporate MDS Consultant completed re-training with the, IDT members including, MDS Nurses, Activities, Social Services , Rehabilitation, DNS, CCC, ADNS and Dietician regarding accurate completion of MDS and review of coding requirements according to the RAI guidelines before 6/21/17 To eliminate repeat deficiencies related to accurate coding of resident MDS, an audit of 5 MDSs weekly, this will be a random selection of quarterly, comprehensive, and significant change assessments, weekly for 12 months. This review will be completed as a collective IDT process, by the DNS and/or Administrative Nurses, Quality Manager/SDC, Activity Director, Therapy Director, Social Work, Dietary Manager/RD, and Admission Director. A QI tool will be completed by the DNS and/or Administrator to identify trends for random and systematic errors for individual residents, and/or the facility in general, will be identified, root cause analysis will be conducted and action plans for random errors will be developed and implemented to correct the potential for MDS coding inaccuracy. A full PIP, using FOCUS PDCA which includes root cause analysis, will be undertaken if the concern is a system concern rather than a random error. Monitoring for compliance: Coding accuracy of the MDS will be tracked monthly for 12 months to identify unfavorable trends and system errors/concerns by the facility IDT. A	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 5	F 278		

anymore. The resident was coded for unintentional weight loss related to failure to thrive. He stated when he coded the nutrition portion of the MDS, he compared the weights, calculated weight loss or weight gain, and looked at the diet ordered and the nurse's notes.

The Registered Dietitian (RD) was interviewed on 5/24/17 at 2:07 PM. She stated the previous RD had coded the MDS for nutrition. The RD stated the resident had a care plan for unintentional weight loss and had some weight loss. She stated the resident was on multiple supplements for weight loss. She thought this section of the MDS may have been coded in error. She would have coded it to say that the resident was not on the physician weight loss regimen for this section. The RD who coded this section of the MDS no longer worked for the facility.

The Director of Nursing stated on 5/24/17 at 3:27 PM that her expectation for MDS was it to be coded correctly for the resident.

2. A partial listing of Resident #34's diagnoses included dementia without behavioral disturbance, unspecified psychosis, manic episode and major depressive disorder.

Resident #34 had a Preadmission Screening and Resident Review (PASRR) done on 11/1/2009. The PASRR number ended in the letter "B". The "B" meant "No limitation unless change of condition. Must stay at skilled nursing facility. No Special services required." Interview with the Admissions Coordinator on 05/23/2017 at 11:02 AM revealed she had been handling PASSR. She said "I know she (Resident #34) is a level II." A level II evaluation is performed by a State mental

summary of monitoring/tracking efforts will be completed and presented at the monthly QAPI Committee by the Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 health authority evaluator. Minimum Data Set (MDS) Nurse #1, who no longer works at the nursing home, coded item A1500 of the Minimum Data Set with an Assessment Reference Date of 2/24/17. The answer to "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" was incorrectly coded as "No." MDS Nurse #2 said MDS Nurse #1 coded that section of the MDS. "She was helping us out, but no longer works here." The MDS Assessment Coordinator signed off overall. MDS Nurse #2 said it is my understanding that it should be coded as "Yes." A review of the assessment revealed MDS Nurse #1 signed for Section A on 3/5/17. The MDS Assessment Coordinator signed that the assessment was complete on 3/13/17. On 5/23/2017 at 11:51 AM, MDS Nurse #2 said, "we have made the correction." RN #1 signed off on the correction on 5/23/17. On 5/24/2017 at 8:19 AM, the MDS Assessment Coordinator, said it should have been coded as 1, meaning "Yes. They fixed it yesterday." On 5/24/2017 at 4:25 PM the Corporate Representative said she expected assessments to be accurate.	F 278		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 281		6/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 7 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement recommendations from the consulting physician following a visit for 1 of 3 resident's reviewed for well-being (Resident # 97). Findings included: Resident # 97 was admitted to the facility on 9/8/15 with the current diagnoses of chronic kidney disease, diabetes and hypertension. The resident was discharged from the facility on 5/19/17. The resident had a care plan in place for potential side effects of medications (created 9/21/15). Resident #97 Minimum Data Set (MDS) dated 3/6/16 revealed Resident #97 was moderately cognitively impaired. The resident needed extensive assistance with bed mobility, dressing, toilet use and personal hygiene. The resident was frequently incontinent of urine. The resident was on a diuretic and antidepressant. A consult note from Nephrology dated 7/6/16 stated obtain a BMP (basic metabolic panel) and PTH (parathyroid hormone test) tomorrow (7/7/16) and in 4 weeks. It also stated that Lasix (a diuretic medication) could be stopped after calcium level normalizes. An order dated 7/7/16 revealed for a BMP and PTH to be drawn tomorrow and in 4 weeks. Laboratory (lab) work dated 7/8/16 revealed that	F 281	F281 For the residents cited: Resident #97 is no longer at our facility. For all residents potentially affected: A review of current resident medical records & outside consultations for the last 90 days, was completed by the DNS, ADON, and Clinical Care Coordinator to ensure written and faxed orders have been implemented timely. There were no additional issues identified. System changes: At the time any outside consultation is received by the nursing staff, the consultation will be called, 7 days a week, to the resident's attending physician for review and approval before the actual orders are initiated by the nursing staff or Provider (NP/PA). A copy will be placed in the Providers (NP/PA) book. Licensed nursing staff have been in-serviced by the DNS on the correct procedure for handling outside consultations (written or faxed). This in-service was completed on 6/17/17. Outside Consultations will be reviewed by the DNS and/or administrative nurses during the daily nurse meeting and chart review to assure that the orders have been carried out timely. Monitoring for compliance: DNS and/or Administrative Nurses will continue to audit outside consultations written and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 8 Resident #97's magnesium level was low at 1.6 mg/dl and calcium level was within normal range. A Fax confirmation revealed that the lab sheet was faxed from the Nephrology office to the facility on 7/18/16. A hand-written a note on the lab sheet indicated to discontinue the Lasix, give Aldactone (a diuretic medication) 25 milligrams (mg) every day, give 800 mg of Magnesium Oxide every day for 7 days, and repeat a Basic Metabolic Panel and Magnesium level in 2 weeks. The Nurse Practitioner had signed the lab and dated it 7/13/16. The Director of Nursing had also initialed the sheet and dated it 8/3/16. A Prescription Authorization sheet from Nephrology dated 7/18/16 stated to discontinue the medication Lasix. The order sheet also ordered Aldactone (a diuretic medication) 25 mg to be given by mouth every day and that 30 pills were to be dispensed with 3 refills. 800 mg of Magnesium Oxide was also to be given every day for 7 days and to dispense 7 pills with no refills. The order sheet also stated to repeat a BMP and Magnesium Level in 2 weeks. The prescription sheet was dated that it was faxed (to the 300/400 nurse's station fax machine) to the facility on 7/18/16 at 1:19 PM with attention to nurse #1. The nurse practitioner had initialed the bottom of the sheet on 8/11/16. There were no additional physician telephone order sheets from 7/18/16 from the NP or Physician. There were no nursing notes from 7/18/16 regarding the nephrology consult of 7/6/16 or the orders from the consult. The Medication Administration Record (MAR)	F 281	faxed utilizing a QI tool, weekly for 4 weeks, then monthly for 2 months, to assure that all written and faxed orders have been implemented timely. DNS and/or Administrative Nurse will complete a summary of all monitoring efforts and present to the facility QAPI Committee monthly for 4 month, then monthly for 2 months, to ensure a trend of compliance is evident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 9	F 281		

from 7/1/16 through 7/31/16 was reviewed and revealed that 20 mg of Lasix was given daily. Orders for the Aldactone and Magnesium Oxide were not present on the July 2016 MAR.
The MAR from 8/1/16 through 8/31/16 revealed that Lasix was stopped on 8/3/16, Magnesium Oxide was started on 8/12/16 and Aldactone was started on 8/18/16.

Another nurse note dated 8/3/16 stated that the resident returned from a follow up nephrology appointment with orders to discontinue the Lasix.

Lab work dated 8/4/16 revealed the resident's Magnesium level was still low at 1.6 mg/dl.

Nurse #1 (who worked first shift on 7/18/16) was interviewed on 5/23/17 at 7:45 AM. She stated that one time (she could not recall date) someone had brought her a fax that she thought was from the date of the resident's nephrology appointment of 7/6/16. However, the date that she actually received the fax was later after the consult date. She stated that she called the Nurse Practitioner to confirm that she still wanted the orders to be followed per the Nephrology recommendation. The NP stated to go ahead and follow the orders from the nephrologist. She stated that she could not remember who gave her the order sheet.

The unit secretary was interviewed 5/23/17 at 7:56 AM. She stated that if she got a fax off of the fax machine, she would give it to the nurse but also the nurse could get the faxes off the fax machine, too. She stated she wasn't involved with Resident #97's nephrology consult sheet. She stated that she usually checked the fax machine several times during the day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 10	F 281		

The NP was interviewed on 5/23/17 at 8:46 AM. She stated that she remembered a time when the Resident #97 had a nephrology consult and had a medication change. She thought the consult sheet never made it to the facility or the faxed sheet got misplaced but the recommendations from the consult were supposed to be implemented. The lack of following through with the consult orders did not cause any adverse effects to Resident #97. She stated the nurse who was caring for the resident did not get the consult sheet with the orders and neither did she. The resident went back for another appointment with the nephrologist and the issue with medications was corrected. She was in contact with the nephrologist several times and the resident's renal status had changed. She stated that according to her notes in August, 2016, she had written to discontinue the Lasix per nephology but as of 7/14/17 the resident was still on the Lasix. She stated that a nurse had called her and stated that she had found a fax sheet from the nephrologist. She stated that she contacted the nephrologist and he stated to go ahead and implement the orders per the recommendations even though it was late.

The Medical Director was interviewed on 5/24/17 at 2:11 PM. She stated that sometimes the consult sheet from appointments would be faxed to the facility. She stated that she wasn't notified of the situation about recommendations that the nephrologist made that were not carried out. She stated that typically if a specialist wrote an order then it should be implemented and she would look over the recommendation as a courtesy. Also, if the provider wrote an order on the lab sheet then she would consider that a physician's order even though it was not written on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 11	F 281		

physician's telephone order sheet. The lab work goes straight to the Nurse Practitioners or her communication book. She looked over the faxed sheet and stated that typically the nurse would just implement the orders from the consult and that she would have signed off later. She was not sure if this resident was given a written prescription for these medications or not.

The Director of Nursing was interviewed on 5/24/17 at 4:10 PM. She stated that she did a medication error report for the nephrologist recommendation not being followed but she was unable to find the medication error report. She stated that she would expect that orders would be followed appropriately from the doctors and from consults. Typically, the nurse would write the recommendation on a telephone order sheet, implement the orders and then would have put them in the consult book for approval.

The Nephrologist's secretary was interviewed on 5/24/17 at 3:54 PM. She stated that she talked to the facility on 8/18/16 and had a note from it. She stated that on 7/18/16 that she called to get the fax number to the facility and that they had seen the resident's lab results and were faxing orders over. The physician wanted to discontinue the Lasix and for Magnesium Oxide and Aldactone to be started based on the lab values. She stated that she faxed the orders to the facility herself. She stated that the resident should have been started on those medications the day she faxed that sheet on 7/18/16.

Two attempts were made to interview the Nephrologist but were unsuccessful on 5/24/17.

On 5/24/17, a note was faxed from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 12 Nephrology office to the facility. The note was dated 8/18/16 and stated the Director of Nursing called to let them know that Resident #97 did not start her Magnesium until 8/11/16. It also stated the facility had just found the order from 7/18/16.	F 281		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:	F 356		6/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 13 (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain daily posting of nurse staffing that included the correct date, total hours, and the daily census for 1 of 4 days of the recertification and complaint survey. Findings Included: During tour on May 21, 2017 at 10:45 AM observation of the Adams Farm Living and Rehabilitation Daily Staffing Posting was dated May 19, 2017. During an interview with the Director of Nursing (DON) on May 21, 2017 at 11:45 AM she indicated that the person who normally does the daily staffing posting left early on Friday. During Tour on May 21, 2017 at 1:45 PM observation of the Adams Farm Living and Rehabilitation Daily Staffing Posting dated May	F 356	F356 For the resident cited: No resident was named For all residents potentially affected DNS completed and posted the Daily Staff Posting, including total hours and current census on May 21, 2017 at 2pm System Changes: DNS completed re-training with the facility scheduler, Administrative Nurses, Licensed Nurses, related to F356, including importance of timely posting of Daily Staffing Posting and to include, include facility name, current staffing for 24 hour, and census. The nurse assigned to 100 hall will be responsible to post the daily staffing sheets in the absence of the facility scheduler.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 14 21, 2017 did not include total hours and current resident census. During an interview with the facility Regional Consultant on May 21, 2017 at 2:30 PM revealed that the person that completed the daily staffing sheet had a family emergency on Thursday. During an interview with the DON on 5/24/2017 at 5:30 PM indicated her expectation was that daily staff posting should be posted daily with the correct date, total hours and daily census.	F 356	Monitoring for compliance: DNS and/or Administrative Nurses will assure that daily posting is in place. Manager on duty for the weekends will assure that daily staff posting is in place for the weekends. Audit of daily staff posting will be audited daily for 4 weeks then weekly for 4 weeks, to assure trend of compliance DNS and/or Administrative Nurse will complete a summary of all monitoring efforts and present to the facility QAPI Committee monthly for 4 month, then monthly for 2 months, to ensure a trend of compliance is evident.	
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		6/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 15 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews and interviews with the pharmacist, the facility: 1) Failed to maintain the cleanliness 2 of 4 medication carts and 1 medication refrigerator in 1 of 2 medication rooms (Front Hall); 2) Failed to date medications when opened in 1 of 2 medication rooms (Front Hall) and 3. Failed to store medications in accordance with the	F 431	F431 For the resident cited: No resident was named Current medication refrigerators were defrosted and medication carts were cleaned on 5/23/17. Undated, opened vials were discarded 5/23/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 16 manufacturer's recommendations in 1 of 3 medication carts (Unit 300). Findings included: 1. Front hall medication room and 100 Unit medication cart A. Observation on 05/23/2017 at 4:59 AM revealed an accumulation of ice inside the freezer portion of the medication refrigerator unit. The thermometer was embedded in the accumulated ice. Interview on 05/23/2017 at 7:30 am with Nurse #4 revealed housekeeping and maintenance was responsible for cleaning the refrigerators. Interview on 05/23/2017 at 7:37 am with Housekeeping Team Leader who stated nursing staff was responsible for cleaning the medication refrigerators. Interview on 05/23/2017 at 7:40 AM with Nurse #5 revealed she just was told by the nursing administration that the night shift nurse were responsible for the cleaning of the medication refrigerator. Interview on 05/23/2017 at 8:42 AM with Nurse #4 revealed the nurses and medication aides were responsible for cleaning of the medication refrigerator. B. In the refrigerator unit there were 2 (two) vials of facility stocked Tuberculin PPD vials (used for skin test in the diagnosis of tuberculosis) that were opened and undated. Review of the manufacturer ' s product information indicated opened vials of Tuberculin PPD injectable medication should be discarded after 30 days.	F 431	Outside pharmacy (PACE) was contacted regarding eye drops and agreed that their method of storage of the identified eye drops would be packaged in a container that will allow upright storage for future medications on 5/24/17. For all residents potentially affected: An audit was completed by the Administrative nurses, on 5/24/17, of medication carts, medication rooms, medication refrigerators and treatment carts to identify any expired, undated, opened vials of medication. No other items were identified. System Changes: A weekly rotation for all medication carts & bi-weekly for refrigerators to be cleaned, by the 11-7 shift nurses, has been developed. Administrative Nurses will complete audits of medication carts, medication rooms, medication refrigerators and treatment carts, to assure medications are stored and dated appropriately, carts cleaned and refrigerators defrosted, daily for 4 weeks, then weekly for 4 weeks to ensure a trend of compliance. Pharmacy consultant and QA Manager will conduct monthly audits, during their monthly visits to assure trends of compliance is evident. A meeting will be completed with the facility DNS and/or Administrator to discuss any compliance issues. DNS and/or Administrative Nurses have in-serviced licensed nurses as of 6/20/17, on the process of keeping medication carts clean, correct storage & dating of opened medication.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 17 " Lidocaine 4% was opened and undated. " Clotrimazole and Betamethasone Dipropionate Cream 1% / 0.05% (a medication used on the skin to treat fungal infections) was opened and undated. C. In the 100 Unit medication cart there was one small white pill exposed in the cart and out of the pharmacy dispensed container. 2. Observation on 05/23/2017 at 8 AM of the Unit 300 medication cart revealed: A. Three (3) blue pills imprinted with the number 144 in the plastic medication cup. There was no name or identification of the pills. B. Six (6) of 12 containers that stored medications inside the cart had an accumulation of trash and a brown colored substance. C. Two (2) pink colored triangle shaped pills outside of the dispensing package were noted within an accumulation of a brown colored substance. D. 1 of the 12 containers that stored medications in the cart had an accumulation of a white colored substance in the corners. E. Prednisolone 1% suspension eye drops were stored lying down on its side in a drawer of the medication cart in a clear box. This box was then placed in a brown paper bag. Review of the manufactures instructions revealed these eye drops must be stored upright. Interview on 05/24/2017 3:42 PM with Nurse #6 should be stored in an upright positioned and shaken well before administration.	F 431	Monitoring for compliance: Administrative Nurses will complete audits of medication carts, medication rooms, medication refrigerators and treatment carts, to assure medications are stored and dated appropriately, daily for 4 weeks, then weekly for 4 weeks to ensure a trend of compliance. DNS and/or Administrative Nurse will complete a summary of all monitoring efforts and present to the facility QAPI Committee monthly for 4 month, then monthly for 2 months, to ensure a trend of compliance is evident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 18 Interview on 05/24/2017 4:10 PM with the consultant pharmacist revealed all eye drops should be stored upright. Interview on 05/24/2017 at 4:29 PM with the director of nurses (DON) revealed her expectations were for staff to store medications appropriately, have clean medication carts and clean medication rooms. Interview via the phone on 05/24/2017 at 5:02: PM with the facility Corporate Representative, DON, Pharmacist (from the dispensing pharmacy of the eye drops) and the Administrator was held. The pharmacist indicated Prednisolone 1% suspension eye drops should be stored upright.	F 431		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must :	F 520		6/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 19 (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility ' s Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 5/26/16 annual recertification survey. This was for recited deficiency in the area of assessment accuracy (F278). This deficiency was cited again on the current recertification survey on 5/24/17. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective QAA Program. Findings Included: This tag is cross referenced to:	F 520	F520 For resident cited: Cross-Reference F278 Medical record for Resident #83 and #34 were reviewed by the Corporate MDS Consultant, related to PASARR and Swallowing/Nutrition. MDS assessment was modified & transmitted on 6/15/17, to reflect accurate coding of Section A and K. For residents potentially affected: Corporate MDS Consultant completed an audit of current resident MDS assessment and cross referenced their medical record to ensure MDS coding is accurate, including Section A and K. Any modifications noted have been made and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 20 F278 - Assessment Accuracy: Based on record reviews and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment for physician prescribed weight loss regimen with significant weight loss, Preadmission Screening and Resident Review level II, cognitive status and weight loss for 3 of 20 sampled residents whose assessments were reviewed. (#28, #34, #83) During the annual recertification survey of 5/26/16 the facility was cited for F278 for failing to accurately code the level of assistance required with activities of daily living for 1 of 4 residents reviewed. An interview with the Administrator and Corporate Representative on 5/24/17 at 4:45 pm revealed the Administrator was new to the facility and would be leading the facility QAA committee. The Corporate Representative stated she had been assisting the facility with their QAA committee. She stated that the committee met monthly and included the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Nurse, Admissions Coordinator, Dietary Manager, Social Services Director, Activities Director and Maintenance Director. She stated the Medical Director and the Consultant Pharmacist met with the committee at least quarterly. She indicated that the facility had worked on ensuring that MDS assessments were coded accurately to reflect the resident ' s condition. The Corporate MDS nurse had completed audits of MDS assessments to determine if they were coded correctly. She stated this auditing would continue.	F 520	transmitted. System changes: To eliminate repeat deficiencies related to accurate coding of resident MDS, an audit of 5 MDSs weekly, will be reviewed for accuracy for a period of 12 months by the DNS and/or Administrative Nurses, Quality Manager/SDC, Activity Director, Therapy Director, Social Work, Dietary Manager/RD, and Admission Director. Trends for random and systematic errors for individual residents, and/or the facility in general, will be identified by utilizing a QI tool, that will be used to record our weekly reviews. At the time of identification of random or systematic errors a root cause analysis will be conducted and action plans for random errors will be developed and implemented to correct the potential for MDS coding inaccuracy. A full PIP, using FOCUS PDCA which includes root cause analysis, will be undertaken if the concern is a system concern rather than a random error. The QAPI Team members will be re-educated by the facility administrator & Corporate MDS Consultant, to ensure they function according to facility QAPI practice and are prompt at identifying unfavorable variances and trends, investigating issues, and initiating/revising plans of action, PIPs and POCs, related to MDS Coding Accuracy. The team includes the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Clinical Care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS FARM LIVING & REHABILITATION	5100 MACKAY ROAD JAMESTOWN, NC 27282

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 21	F 520	Coordinator, Quality Manager/SDC, Wound Nurse, Activity Director, Therapy Director, Maintenance Director, Social Work, Dietary Manager, and Admission Director. Monitoring for compliance: Coding accuracy of the MDS will be tracked monthly for 12 months to identify unfavorable trends and system errors/concerns by the facility IDT. A summary of monitoring/tracking efforts will be completed and presented at the monthly QAPI Committee by the Administrator.	