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 04/16/2018

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
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have an Emergency Preparedness plan (EP). The EP plan did not include facility and community based risk assessments which includes missing residents, the facilities resident population, a process that includes collaboration with local, regional, state and federal officials. The plan did not have any policy or procedures regarding the emergency plan, the provision of needs for staff and residents, evacuation, sheltering of residents and	E 001	E 001 Emergency Plan • The plan for correcting the specific deficiency: o The facility had an emergency plan but the organization of the manual made it difficult to verify that the required components were present. o A new manual will be developed and organized in a way to provide easy reference, and including the required components.	5/14/18

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

Electronically Signed | 05/04/2018

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E 001	Continued From page 1 staff that remain in the facility and the transportation of medical records. The EP plan did not have any documentation regarding arrangements for other facilities to receive patients in the event of evacuation. The communication plan did not address names or contact information for staff, resident ' s physicians or other facilities. The EP plan did not have a way to share information and medical documents of a resident with another facility. The plan failed to have a training program as well as an emergency and standby power system. Findings included: 1A: A record review of the EP manual revealed that the manual did not include a community or facility based risk assessment and strategies. Further review revealed the manual also did not include missing residents in their EP program. B: A further review of the EP manual revealed that the resident population with in the facility was not addressed as well as the residents who needed special care like oxygen and immobility. The plan did not address the type of services the facility was capable of providing to the residents during an emergency situation. The continuity and succession plan was not included in the EP plan and the risk assessment for the facility was not completed. C: The review of the EP manual revealed that there was not any criteria listed for residents or staff who would be sheltered in the facility during an emergency. The EP manual also did not have any procedure for sheltering residents, staff and others who needed to remain in the facility in the event evacuation could not occur.	E 001	• Procedure for implementing the plan: o The facility Administrator, corporate representative, and facility safety committee have reviewed, and updated our current manual, as of May 14, 2018, to include: 1A) A Community/Facility based risk assessment and strategies, including missing resident. B) Current facility risk population identified, including residents needing special care like oxygen and immobility and services the facility is capable of providing to residents during an emergency situation. C) Shelter in place criteria for residents and/or staff who need to remain in the facility in the event evacuation could not occur D) Maintaining confidentiality of resident medical records during an evacuation or transfer to another facility, during an emergency. E) Communication Plan, including name, contact information for all staff working in the facility, contact information of resident's attending physician, and contact information of facilities available to provide care and services to residents in an emergency. F) Communication plan to include how resident information and medical documents will be shared with other facilities and health care providers to ensure continuity of care. G) Communication plan to include how emergency plan information that is shared with facilities residents, family members and resident's representative.	

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E 001	Continued From page 2 D: The EP manual revealed a lack of policies and procedures on how the resident ' s confidentiality would be maintained, how the resident ' s medical record information would be protected and how the resident ' s medical record would be available for continuity of care when evacuated or transferred to another facility during an emergency. E: A record review of the EP manual revealed that the communication plan did not include name and contact information of all the staff working in the facility, name and contact information of the residents physicians and name and contact information of other facilities including but not limited to their sister facility that would be providing care and services to residents during an emergency. F: A review of the communication plan did not include processes or procedures that would indicate how resident information and medical documents would be shared with other facilities and health care providers who would be providing continuity of care for residents who are sheltered by other facilities and at other locations during an emergency situation. G: The EP manual revealed that the communication plan did not have any documentation as to how it would share the emergency plan information with the facilities residents, family members and/or the resident ' s representative. H: A review of the EP manual revealed that there was no training program or testing requirements documented in the plan.	E 001	H) A process for testing and training requirements of this plan. I) Identified emergency power system that is in place in case of a power failure during an emergency situation. The Safety Committee members, including Safety Director, Staff Development, HR, and Administrator will educate the facility staff and residents, May 14, 2018, on the updated information related to the Emergency Program. • Monitoring procedure o The risk assessments will be conducted annually and the plan updated as needed. o The emergency plan will be evaluated annually by the Safety Committee to ensure the contents are current. • Title of the person responsible for implementing the plan: o The Executive Director (Administrator) • Date the plan will be completed o May 14, 2018	

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E 001	Continued From page 3 I: The EP plan did not have information listed as to an emergency or stand by power system in case of a power failure during an emergency situation. An interview on 4/13/18 at 3:45 pm with the Administrator revealed the facility emergency plan had been provided by the corporate office. She stated the facility had planned to shelter in place and had not arranged for an alternate location to evacuate to. The Administrator added she needed to re-evaluate and update the facility emergency plan to include all of the required components.	E 001		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		5/14/18

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F 609	Continued From page 4 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit a 24 hour and 5 day report to the state of North Carolina for an allegation that the facility received for 1 of 1 cases reviewed for misappropriation of property (Nurse #2). Findings included: On 4/11/18, the Administrator provided a file on complaints she had received against nurse #2. In the file provided revealed an allegation that was sent to the facility via email dated 2/7/18 that stated 2 employees had been taking medications from the facility for personal use. The first allegation came via email to the facility and stated ..."your employee nurse #2 takes Zofran and other over the counter pills on a regular for her and herself and kids, and she named another employee" ... On 4/11/18, the Administrator provided a file on complaints she had received against nurse #2. The file provided by the facility on 4/11/18 revealed the facility had conducted and completed a thorough investigation of the allegation, which was completed on 2/9/18. The facility contacted the police department to report the incident, accounted for all the medications that were alleged to be taken, interviewed staff	F 609	F 609 Reporting alleged violations • The plan for correcting the specific deficiency: o The facility did not believe the incident cited in the 2567 warranted a 24 hour or 5 day report because it was immediately determined to be a case of domestic dispute rather than a true misappropriation of property. The 24 hour and 5 day reports have now been submitted. o Going forward, all allegations of abuse, misappropriation of property, neglect, exploitation, or mistreatment will be reported within 2 hours (abuse or bodily injury) or 24 hours, and a final report will be submitted within 5 days. • Procedure for implementing the plan: o Staff, including Administrative, Nursing, Dietary, Housekeeping, Laundry and Rehabilitation were educated, May 14, 2018, that all allegations of abuse, misappropriation of property, neglect, exploitation, or mistreatment will be reported within 2 hours (abuse or bodily injury) or 24 hours, and a final report will be submitted within 5 days, even if investigated and unsubstantiated prior to 2 or 24 hours.	

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F 609	Continued From page 5 involved and the board of nursing was notified regarding the incident. The alleged staff members also underwent in-service training regarding medications diversion. The facility found the incident to be unsubstantiated. The administrator was interviewed on 4/1/18 at 2:23 PM. She stated that she did not report the incident to the state because she looking into the concern immediately and determined that it was domestic dispute between an employee and an ex- boyfriend. She stated based on the research that she did, she concluded it was a domestic connection. The administrator was interviewed on 4/13/18 at 4:59 PM. She stated that her report/investigation was completed correctly.	F 609	• Monitoring procedure: o All grievances and investigations will be reviewed by the Quality Management Team, daily Mon-Fri at morning team meeting, to ensure the reporting requirements were met. o The Quality Management Team will alter this plan if they find further instances where the 24 and 5 day reports were not submitted timely. • Title of person responsible for implementing the plan: o The Executive Director (Administrator) • Date the plan will be completed o May 14, 2018	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns.	F 636		5/14/18

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F 636	Continued From page 6 (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization	F 636		

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F 636	Continued From page 7 or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete the comprehensive admission minimum data set (MDS) assessment by the 14th day of admission for 1 of 22 sampled residents reviewed for MDS assessment (Resident #175.) Findings Included: Resident #175 was admitted to the facility on 3/26/18 and diagnoses included gastroenteritis, dysphagia, osteoporosis, depression, anxiety and asthma. Review of the admission minimum data set (MDS) with an assessment reference date (ARD) of 4/2/18 was not completed until 4/11/18. An interview with the MDS Nurse on 4/12/18 at 4:00 pm revealed the 14 day comprehensive MDS for Resident #175 was not completed until 4/11/8. He stated the Social Worker (SW) who was responsible for sections, C, D, E and Q had not completed them until 4/11/18. The MDS Nurse added the care area assessments (CAA ' s) were also not completed until 4/11/18. He stated the 14 day comprehensive assessment was late and should have been completed by 4/8/18. An interview with the SW on 4/12/18 at 4:36 pm revealed she was responsible for completing sections C, D, E and Q of the 4/2/18 MDS for Resident #175. The SW stated she had not completed those sections of the MDS on time	F 636	F 636 Comprehensive Assessments and Timing • Plan for correcting the specific deficiency: o During our annual survey it was identified that an MDS for Resident #175 was not submitted timely. This was an oversight of our IDT team. That MDS was submitted during the annual survey but it was late per requirements of the RAI manual. o Going forward, all MDSs will be submitted (transmitted) according to the requirements of the RAI manual. • Procedure for implementing the plan: o An audit of the MDSs for the last three months was conducted to determine if we had a system issue, or if this was an isolated event. No system issues were identified. o Going forward, all MDSs will be submitted (transmitted) according to the requirements of the RAI manual. o A training program was provided on April 25, 2018, to the entire IDT, including the two MDS coordinators, reviewing the requirements for completing the MDS, transmitting according to RAI time frames, completing CAAs, and developing care plans. • Monitoring procedures o During our daily morning meeting, the team will verify that all MDSs that are due, have been transmitted. o Using an audit tool, all completed	

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F 636	Continued From page 8 because she was new and had been very busy. An interview with the Administrator on 4/13/18 at 5:12 pm revealed it was her expectation that residents receive quality care and that included completion of the comprehensive admission MDS by the 14th day of admission.	F 636	MDSs will be reviewed weekly for 60 days, then monthly for 12 months, by the Executive Director and a corporate representative to ensure the MDSs were completed and transmitted according to RAI requirements. o A record of this review will be presented to the Quality Management Team each month and the plan will be modified if additional MDSs are late. • Title of person responsible for implementing the plan: o The Executive Director (Administrator) • Date the plan will be completed o May 14, 2018	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (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 administer the correct dose of a medication for 1 of 7 resident reviewed for unnecessary medications (Resident #76). Findings included: Resident #76 was admitted on 4/5/16 with the diagnosis of chronic kidney disease, hypertension and gastroparesis. Resident #76 Minimum Data Set (MDS) dated	F 658	F 658 Services that meet professional standards • Plan for correcting the specific deficiency: o The nurse transcribed an order for Reglan 5mg po TID for resident #76 instead of Reglan 10 mg po TID as ordered by the physician. The order was corrected immediately and the physician was notified of the error. o A medication error report was completed and will be brought to the next	5/14/18

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F 658	Continued From page 9 3/4/18 revealed the resident was moderately cognitively impaired. The resident was receiving an antidepressant, diuretic and anti-psychotic medication. The resident had care plans in place for bed mobility, diabetes, nutrition and falls (updated on 3/8/18). A physician's telephone order sheet dated 4/9/18 stated to "change Metoclopramide to 10 milligrams (mg) three times a day before meals" (a medication used to promote motility in the upper gastrointestinal tract). The telephone order had a faxed date of 4/10/18 at 9:55 AM. Resident #76 Medication Administration Record (MAR) for 4/2018 revealed that the resident was getting 5 mg of Metoclopramide before meals three times a day from 4/7/18 through 4/13/18. Medication aide #1 was observed for medication pass on 4/12/18 at 4:21 PM. She was observed to give resident #76, 5 mg of Reglan by mouth before dinner. The physician was interviewed on 4/13/18 at 12:30 PM. He stated that the resident had been on (Reglan) Metoclopramide 10 mg but then the pharmacist wanted then the decrease the dose and the resident went to the hospital. The resident had gastroparesis, a loss of appetite and hypoglycemia. The hospital discharge summary stated the resident had only 5 mg ordered so he increased it to 10 mg on Monday (4/9/18). He stated that he wrote the order and made sure his nurse (nurse #3) gets the orders and she would give the order to the facility so it could be followed.	F 658	Executive QI Committee for further review. o In the future, orders will be transcribed correctly. • Procedure for implementing the plan o A 100% audit was conducted on all physician orders immediately on 04/12/18 and completed on 04/13/18. No additional transcription errors were identified. o Currently a nurse inputs a specific physician order from a telephone order into the computer physician order system. This nurse is a charge or nurse manager. A nurse manager audit is done of the telephone order against the electronic order input to verify the accuracy and clarity of input. When order input is completed and 'sent' the pharmacy compares the electronically input order to the faxed order for accuracy and clarify. The order is then returned to the facility via the system called E-Link with clarification, or request for clarification, as needed and/or a request for the nurse to accept or reject. This will continue. o Added to our process of verifying medication transcription, going forward the charge nurse will be responsible to check the new order entered into the physician order system with second nurse prior to sending the order for the nurse manger's audit. o The nurses were educated on the change in our process for verifying transcription of medications on May 14, 2018. • Monitoring Procedure o A QI monitoring tool was developed to monitor and audit all new physician orders	

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F 658	Continued From page 10 Nurse #1 was interviewed on 4/13/18 at 1:48 PM. She stated that sometimes the doctors (for outside appointments) would fax orders to the facility or they would have a nurse come and bring the actual telephone orders. Once the order was in the chart as a telephone order, the nurse that actually gets the order would put it in the computer and the MAR would automatically update to reflect the new order. Nurse #2 was interviewed on 4/13/18 at 1:49 PM. She stated that generally orders are faxed and the nurse would also bring in the original order itself. When they get the fax order they will put the order in the computer and would fax it to pharmacy. The MAR is updated when they put the order in the computer. The nurse responsible is the one the patient has that day. She stated that Resident #76 was recently in the hospital and the order for Reglan was changed at the hospital. She also added that occasionally the nurse will hand her the original physician's orders. Supervisor nurse #1 was interviewed on 4/13/18 at 2:12 PM. She stated that most days, she worked till 5:00 PM and was the supervisor for the 400 hall (Resident #76 hall). She stated that she does not recall speaking to the nurse #3 on Monday. She stated that if there was a new written telephone order then they would transcribe it onto their orders and put it in the computer, as well. She stated that clinics usually fax over the orders and then bring over the original written order. The orders for resident #76 were usually faxed. The nurse will take the fax off the fax machine or if the order goes to another fax machine whoever pulls the order off would take it to the nurse that has that resident.	F 658	for accuracy for the next 3 months. This audit will be conducted by the SDC/QI, DNS, ADON and Clinical Care Coordinator. o The results of the audit will be reviewed and recommendations made monthly by the Quality Management Team. • Title of person responsible for implementing the plan: o The Director of Nursing Services • Date the plan will be completed o May 14, 2018	

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F 658	Continued From page 11 Nurse #2 (worked day shift on 4/10/18) was interviewed again on 4/13/18 at 4:31 PM. She stated that the resident had not had any nausea, vomiting or pain. She stated that she never saw the physician's order come through. Nurse #3 was interviewed on 4/16/18 at 9:07 AM. She stated that she would fax physician's orders over to the facility then the original order would be taken to the facility later. She stated that the order for 10 mg of Reglan was written and she was at the facility on the 4/10/18 and took the original order to the facility. She could not answer if she faxed the physician's order over to the facility or not as she could not remember. She stated that she got the order on the 10th and gave it to the nurse #2. The resident was seen for her appointment on 4/9/18. The administrator was interviewed on 4/13/18 at 4:59 PM. She stated that she would expect to provide quality of care services at Adam's farm including transcription of orders correctly.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		5/14/18

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 04/16/2018

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

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F 684	Continued From page 12 Based on record review and staff interviews, the facility failed to monitor a cardiac device for 1 of 1 residents reviewed who had a cardiac device (Resident #266). Findings included: The Technical Cardiomessenger Smart device manual dated 10/5/17 stated "At the very latest, the CardioMessenger must be charged when the battery icon flashes. The CardioMessenger automatically receives the information from your implanted device and transmits it to the BIOTRONIK Service Center. Therefore, there are only a few points that need to be considered. Check once a day whether your CardioMessenger is switched on and ready for yourself, if you want to use the CardioMessenger in mobile operation, we recommend that you make a habit of charging it every night on the bedside table. Once the connection is established, the operation and battery icons (displayed on the device) remain permanently activated." Resident #266 was originally admitted to the facility on 8/3/17 with the diagnoses of seizures, heart failure, and chronic kidney disease. A note from the cardiologist dated 8/3/17 revealed that resident #266 had an "implantable cardioverter-defibrillator in place - biotronik ICD implant 4/15/15." Hospital records discharge summary dated 12/1/17 revealed the resident had a cardiac pacemaker (a small device placed in the chest or abdomen to help control abnormal heart rhythms) and cardiac defibrillator (ICD) (a device that	F 684	F 684 Quality of Care • Plan for correcting the specific deficiency: o The facility admitted resident #266 on 12/01/17. The facility was unaware that the resident used a Biotronik monitor, it was not on the discharge summary from the hospital, and the facility did not know how the device arrived at the facility. There were no orders for monitoring this device. o During the annual survey, when the device was identified, the facility immediately called the cardiologist to obtain orders for the Biotronik monitor. o The facility added a nursing measure (requires check-off on the MAR) for the staff to check daily to ensure that the monitor was plugged into power. o Going forward, the facility will ensure that all residents who have monitoring devices of any type are identified on admission, and instructions for care / monitoring of that device are relayed to nursing. • Procedure for implementing the plan o A 100% audit was conducted for all other residents that might have a monitoring device that had not been identified on April 12, 2018. There were no other monitors that had not previously been identified o For all new admissions, an inventory inquiry has been developed that will be completed during the admission process to identify any monitoring devices or other equipment on admission. o Based on the admission inquiry, a nursing measure (requiring check off on	

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F 684	Continued From page 13 sends a low-energy shock that resets an abnormal heartbeat back to normal). Hospital records discharge summary dated 12/1/17 revealed the resident had a cardiac pacemaker and cardiac defibrillator (ICD). Resident #266 Quarterly Minimum Data Set (MDS) dated 2/21/18 revealed the resident was moderately cognitively impaired. The resident required extensive assistance with bed mobility, transfers, dressing and personal hygiene. The resident had an active diagnoses of heart failure, hypertension, seizure, gout and atrial fibrillation. The resident was on anticoagulant and diuretic medication. A note from the physician (at the facility) dated 3/2/18 revealed the resident had a past surgical history of a cardiac defibrillator and cardiac pacemaker in 2016. The resident was seen on this date for a 7 pound weight gain in a week. Review of the resident's physician's orders revealed there were no orders for monitoring for a cardiac device (the device looks like a smartphone, is designed for stationary use when placed on a patient's night stand, as well as mobile use. It receives information from the implanted device at night while patients sleep) cardiac pacemaker or cardiac defibrillator. Review of Resident's #266 chart revealed there were no documentation of monitoring of a cardiac device or of the resident's pacemaker/ICD. Resident #2 was interviewed on 04/11/18 at 9:38 AM. He stated that he had pacemaker and it had a battery device that was on his nightstand. He	F 684	the MAR) will be added, instructing nursing to on how to monitor the device. o If the hospital discharge orders do not include instructions regarding a device, the physician will be contacted for instructions. o Nurses were educated, May 14, 2018, on the inventory inquiry, and the need to add a nursing measure instructing staff to monitor any device according to the requirements of that device. • Monitoring procedure o A QI monitoring tool was developed to monitor any devices brought into the facility during the next 3 months. This audit will be conducted by the SDC/QI, DNS, ADON and Clinical Care Coordinator daily for one month then weekly for 3 months and quarterly for 3 months. o The results of the audit will be reviewed by the Quality Management Team and changes to the plan will be initiated if the problem continues. • Title of person responsible for implementing the plan: o The Director of Nursing Services • Date the plan will be completed o May 14, 2018	

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	345535	A. BUILDING _____ B. WING _____	C 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 14	F 684		

stated that there was a week that it was on the floor and was uncharged and he was unable to reach it.

An observation of the device was conducted on 4/11/18 at 9:38 AM. The cardiac monitoring device (looked similar to a smart phone) was charging on the resident's bedside table.

Nurse #2 (400 hall nurse) was interviewed on 4/12/18 at 3:21 PM. She stated the resident needed to be reoriented every day. She stated that she didn't know about a cardiac device for this resident or the device that was in the resident's room.

The cardiac monitoring device was observed on 4/12/18 at 3:35 PM with the unit supervisor #1 and the nurse #2. Nurse #2 stated that the device said it was "on" and "ok". The cardiac monitoring device was observed on the resident's bedside table plugged in and charging.

Nurse Supervisor #1 was interviewed on 4/12/18 at 3:35 PM. She stated that she thought the resident brought the device in from home. She stated she did not think it was a medical device. She stated she thought the device was brought in from home as the resident brought in a lot of office stuff that he liked such as a printer and computer.

Nurse #4 was interviewed on 4/12/18 at 4:40 PM. She stated that the resident had some confusion. She stated that she was not sure if the resident had monthly checks on the phone for his pacemaker or if he was sent out monthly for appointments. She stated that usually the clinic would send a note stating when his pacemaker

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 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 15	F 684		

needed to be checked and would schedule an appointment in advance so the facility would know when to call so the device could be checked. She stated the resident had no other type of cardiac monitor that she knew of. She stated that usually the pacemaker will be under the resident's diagnosis in the chart and in the discharge summary if the patient has one. The patient had no issues with his heart that she knew of. She also stated that she has never seen a cardiac monitoring device for this resident before and she checked and helped the resident with his continuous positive airway pressure device (CPAP) at night.

The cardiac monitoring device was observed again with nurse #4 on 4/12/18 at 4:48 PM. The device stated "cardio messenger" on the back of it.

Nursing Assistant #1 was interviewed on 4/13/18 at 9:38 AM. She stated she did not know about any cardiac monitoring device but knew the resident had a pacemaker.

The Cardiologist was interviewed on 4/16/18 at 5:09 PM. He stated the resident had a biotronic device with an implanted ICD and pacemaker. He stated that daily, the company got data from the device. If there was an alert then the data was forwarded to them (Cardiology). The daily download included cardiac characteristics that was programed for the device. An example would be an atrial event that occurred and the information would be sent to the device's company and then forwarded to the cardiologist office. There used to be quarterly battery checks for some devices. This device would tell information if the device discharged, interrogation

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 04/16/2018

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F 684	Continued From page 16	F 684		

information, if the device delivered therapy, the last pacing information, voltage level, any cardiac lead impediment, battery charge and atrial and ventricular pacing information that would be downloaded daily. If the device was not plugged in then no information would be received for that amount of time and the company would usually call the patient. This patients had data downloads for 2/16/18, 11/17/17 and some in 8/2017 and 7/2017. He stated that there was some missing data for November and December, 2017. He stated from 11/27/17 through 12/15/17 there was no device data for those dates but there was a summary of data for those dates that indicated if the device discharged (delivered a shock) He stated that if the device was left uncharged it would not cause the resident to have an adverse reaction as the implanted device would still discharge. Some missing data usually was not a big deal but daily transmissions were uploaded online and gave them (cardiologist) an idea of what's going on (cardiac wise). For these devices, the green light meant the device was on, which meant the device was collecting information and sending data to the company. He stated the hospital discharge summery indicated the resident had an ICD and pacemaker. He stated that he just consulted the patient in the hospital and did not complete the discharge summary so he would not be the one to write the orders for the device and that the hospitalist wrote all the patient's discharge orders. He stated they always talked with the patient's family about the device. He also added that the resident did have an upcoming follow up cardiology appointment.

The Medical Director was interviewed on 4/13/18 at 11:21 PM. She stated that the resident did have a pacemaker and ICD and was followed by

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 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 17 cardiology. She stated that according to documentation from UNC healthcare on 1/8/18 the resident's cardiac monitor showed that a battery check was completed. She stated that she did not know about the cardiac monitoring device and it was managed by the cardiologist. The cardiac monitor could potentially keep track of different things but she would not be the one involved in it. She was not sure who did the monitoring of the device but it was not her as she was not a specialist. She stated that she didn't know exactly what was monitored on the device and that was a question for cardiology. She added that she would never write orders for those monitors as that would be out of her scope of practice as she was not the cardiologist. She would only look over the specialist orders and sign them if appropriate. The resident had had no cardiac symptoms that she knows of. She stated that on 11/17/17 according to UNC's documentation, the resident had a pacemaker problem and they called the facility and documented the phone call but that was all she could see. The Director of Nursing (Administrator was present) was interviewed on 4/13/18 at 5:01 PM. She stated that they had no information/orders..etc. about the cardiac monitoring device so the facility did not know about the device.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 692		5/14/18

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	345535	A. BUILDING _____ B. WING _____	C 04/16/2018

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F 692	Continued From page 18 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to administer tube feeding as ordered by the physician for 1 of 5 residents reviewed for nutrition (Resident #97.) Findings Included: Resident #97 was admitted to the facility on 3/12/18 and her diagnoses included brain hemorrhage and dysphagia. A baseline care plan dated 3/12/18 for Resident #97 identified the resident was at nutrition risk related to NPO (nothing by mouth) status, forehead laceration and wound to cheek. Enteral Nutrition via PEG (percutaneous endoscopic gastrostomy tube) to meet nutrition needs. Goals included Resident #97 would not show any significant weight changes. Interventions included Registered Dietitian (RD) to evaluate and	F 692	F 692 Nutrition /Hydrations status maintenance Plan for correcting the specific deficiency: o Nurses did not administer Osmolite 1.2, for resident #97, because communication broke down and the message that the resident had not consumed 50% of her meal did not reach the correct person. o Attending physician, the medical record for resident #97 and clarified the order to read give Osmolite 1.2 via PEG BID to support nutritional status. o The physician order was clarified to give a better understanding of her intent. • Procedure for implementing the plan: o The Quality weight committee met and discussed this type of order with the physician. o The committee and the physician	

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	345535	A. BUILDING _____ B. WING _____	C 04/16/2018

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F 692	Continued From page 19 follow-up per facility protocol, review drug regimen for possible medications that may interfere with dietary intake, weigh resident per facility protocol, record results and report any loss to physician and RD. Review of an admission minimum data set (MDS) dated 3/26/18 for Resident #97 revealed her weight was 188 pounds (lbs.), she had not experienced any significant weight loss or gain, had a feeding tube which provided 51% or greater of her calories and 501 cc ' s or greater of fluids daily and had impaired cognition. Review of the weight record for Resident #97 identified her weights were: 188.8 lbs. on 3/14/18, 187.6 lbs. on 3/21/18 and 176.6 lbs. on 3/30/18. This reflected an 11 lb. / 5.8% weight loss in 7 days. Review of the physician orders for Resident #97 revealed an order dated 4/6/18 to administer 1 can of Osmolite 1.2 three times daily if resident consumed less than 50% of her meals. Review of the April 2018 medication administration record (MAR) for Resident #97 revealed an entry with an order date of 4/6/18 to administer 1 pack of Osmolite 1.2 cal bolus feeding via g-tube three times daily if resident eats less than 50% of meals. The scheduled times were 9:00 am, 1:00 pm and 5:00 pm. The MAR identified 1 can of Osmolite 1.2 had been administered on 4/11/18 at 5:00 pm. There were no other entries that identified administration of the Osmolite 1.2. A progress note written by the RD dated 4/9/18 for Resident #97 stated weight was 176.6 on	F 692	decided that an order of this type may continue to cause confused interpretation. Therefore, it was decided, along with the Medical Director that orders based on meal consumption would not be utilized. o All residents requiring bolus feedings will be reviewed, by the Registered Dietician and Director of Nursing Services, at the weekly Quality Weight Meeting to assess their weight, their orders and proper administration of any bolus feeding. • Monitoring procedure o A tracking tool / audit will be used weekly for 3 months, then monthly for 3 months, then quarterly to track accuracy of orders / and administration of bolus feedings. o The results of this audit will be reviewed by the Quality Management Team and the plan will be altered if additional issues are identified. • Title of person responsible for implementing the plan: o The Director of Nursing Services • Date the plan will be completed o May 14, 2018	

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 04/16/2018

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F 692	Continued From page 20	F 692		

3/30/18 - 6.4% loss x 7 days. Suspect weight loss was related to fluid. Resident noted with edema on admission and now improved. Resident on a mechanical soft diet and Osmolite 1.2 one can bolus via g-tube if ate less than 50% of her meal. Documented meal intake noted to be 50 to 75% over the past 3 days. No new interventions. Weigh per facility protocol.

Review of the meal and snack intake roster dated 4/6/18 through 4/12/18 for Resident #97, provided by the nurse supervisor, revealed on 4/7/18 the resident had refused her supper meal (including alternates offered) nurse notified and on 4/9/18 the lunch meal intake was documented as 25% (including alternates offered) nurse notified.

An observation of Resident #97 on 4/12/18 at 12:24 pm revealed she was sitting in a chair in her room eating her lunch meal. The resident had received ground pork with gravy, a baked sweet potato, brussel sprouts, a roll, a piece of cake, a glass of iced tea and a glass of water. The resident was feeding herself and consumed approximately half of the pork, all of her cake and all of her iced tea. The resident stated "to help myself to some cake; it was in the kitchen."

An interview on 4/12/18 at 2:51 pm with Nursing Assistant (NA) #2 revealed she was the NA for the resident. She stated the resident had been eating well and could feed herself. The NA stated she recorded how much the resident ate of her meals in the computer. She added if the resident ate less than 50% of her meal she was supposed to report it to her nurse. The NA stated she did not know if the resident had lost any weight.

An interview on 4/13/18 at 11:37 am with the RD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 692	Continued From page 21 revealed Resident #97 had some significant weight loss related to fluid. She stated the resident ' s tube feeding had been changed to bolus feedings if she ate less than 50% of her meal. The RD added the resident received a mechanical soft diet and her intake had been 100% of her meals the past 7 days. An interview on 4/13/18 at 12:39 pm with Nurse #5 revealed she was the nurse for Resident #97 on 4/9/18. She stated she had not administered the bolus feeding that day because the NA had not notified her that she had only consumed 25% of her lunch meal including alternates offered. Phone interviews were attempted on 4/13/18 at 12:55 pm and 1:15 pm with the nurses that worked with Resident #97 on 4/7/18 with no response. An interview with the Director of Nursing (DON) on 4/13/18 at 3:23 pm revealed two nurses had split the second shift on 4/7/18. She stated the oncoming nurse had been told that Resident #97 had eaten 50% of her supper meal and did not require any bolus feedings. The DON added it was her expectation that residents received their tube feeding as ordered by the physician.	F 692		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced	F 867		5/14/18

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F 867	Continued From page 22 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 5/24/17 annual recertification survey. This was for recited deficiency in the area of services provided meet professional standards (F 281.) This deficiency was cited again during an annual recertification and complaint investigation survey conducted on 4/13/18. 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: 1. F 658 - Services provided meet professional standards: Based on record review and staff interviews the facility failed to administer the correct dose of a medication for 1 of 7 residents reviewed for unnecessary medications (Resident #76.) This deficiency (F 281) was originally cited during an annual recertification survey conducted 5/24/17 for failure to implement recommendations from the consulting physician following a visit for 1 of 3 residents reviewed for well-being (Resident #97.) An interview with the Administrator on 4/13/18 at 4:55 pm revealed the facility continued to evaluate consultant physician recommendations daily. She stated the transcription error identified was a random error. The Administrator added the	F 867	F 867 QAPI / QAA Improvement Activities • Plan for correcting the specific deficiency o The random error, one nurse making a transcription error, identified in the 2018 annual survey was corrected during the survey. o The facility will maintain an effective QAA program through its Quality Management Team. This team will continue to meet monthly, reviewing audits of various systems, including transcription of medication orders, and implementing improvement projects when system issues are evident. • Procedure for implementing the plan o A tracking tool will be used to record, and trend, medication transcription errors. The Quality Management (QAPI) Team will review this tracking tool monthly, implementing interventions such as nurse education, if errors are evident. o Tracking systems for other processes, such as weight loss, falls, pressure ulcer prevention etc will also continue to reviewed monthly, and improvement projects initiated if system issues are evident. o The Quality Management Team will be re-educated on their role in monitoring and maintaining clinical and operational systems. This training will include: the purpose of a QAPI program, the systems that need to be monitored, how to do the monitoring, how to implement improvement plans, and how to monitor those plans to ensure they are effective	

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 04/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 23 quality assurance team works to prevent system errors and random errors are difficult to prevent.	F 867	• Monitoring procedures o The Quality Management Team (QAPI) minutes and tracking / trending tools will be reviewed by a Century Care Management corporate representative monthly for 12 months to ensure the team is discussing and addressing issues identified. The corporate representative will meet with the facility Management Team if their minutes and tracking tools do not indicate effectiveness. • Title of person responsible for implementing the plan: o The Executive Director (Administrator) • Date the plan will be completed o May 14, 2018	