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 07/06/2018

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
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		7/31/18

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

Electronically Signed | 07/25/2018

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

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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to notify a resident's responsible party after the resident got her left foot caught under a wheelchair while being transported in the hallway which later revealed a non-displaced distal fracture of the tibia and fibula for 1 of 4 residents sampled for supervision to prevent accidents (Resident #3). Findings included: Resident #3 was re-admitted to the facility on 06/27/16 with diagnoses which included kidney disease, Type 2 diabetes, osteoarthritis of left knee, osteoporosis, Alzheimer's disease, dementia, anxiety and depression. A review of a care plan with onset date of 02/01/18 revealed Resident #3 had a diagnosis of osteoporosis and was at risk for injury or fracture related to changes in bone structure and bone density. The goals indicated in part staff would implement interventions to maintain a safe environment daily to reduce risk for injury. A review of an annual Minimum Data Set (MDS) dated 04/22/18 indicated Resident #3 had short	F 580	F 580 Notification of Changes Plan of correcting the specific deficiency: 5/20/18, Nurse #1 did contact the resident RP and attending physician, reporting the resident change in condition, of increase swelling & pain noted of left leg. Order for x-ray was obtained and Nurse #1 documented x-ray results in the medical record for resident #3. Nurse #1 failed to notify resident #3□s attending physician & resident representative (RR) of the incident on 5/19/18. The root cause of this deficiency is that Nurse 1 did not perceive the event of 5/19/18 to be an incident requiring notification. Nurse #1 is no longer employed as of 5/23/18. Procedure for implementing acceptable plan of correction: The facility Administrator completed an audit of resident incidents for the previous 30 days to ensure notification was made to the attending physician & resident representative. This audit was completed as of July 9, 2018. Any opportunities were corrected by the Nurse Managers by July 13, 2018.	

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F 580	Continued From page 2 term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #3 was totally dependent on staff for bed mobility, transfers and locomotion on and off the unit. A review of a facility document titled Occurrence Report completed by the Director of Nursing (DON) indicated on 05/19/18 at 5:00 PM an incident had occurred when Resident #3 was being transported in a wheelchair and her left foot was caught under the chair. A review of nurse's progress notes dated 05/19/18 revealed there was no documentation of notification to Resident #3's responsible party (RP) after Resident #3's left foot was caught under the wheelchair. A review of a facility document titled Investigation Summary dated 05/20/18 indicated on 05/19/18 at approximately 5:00 PM, NA #1 was transporting Resident #3 to the dining room in her wheelchair when Resident #3 suddenly dropped her foot while NA#1 was pushing the wheelchair and Resident #3's foot was caught under the chair. The document further indicated Resident #3 called out and NA #1 immediately stopped the chair and told Nurse #1 what had happened. The document revealed Nurse #1 assessed Resident #3's leg and did not observe swelling at that time and Resident #3 did not complain of pain when she attempted range of motion. The document also revealed Nurse #1 stated she had gotten busy during the shift and had forgotten to call Resident #3's representative (RP). The document indicated Resident #3's RP had stated she was not notified on 05/19/18 after the incident had occurred. The document further indicated	F 580	Licensed nursing staff, RN□s & LPN□s, have been re-educated on notifying a resident□s representative and attending physician of incident/accidents that have the potential to result in injury as well as changes of condition and the documentation requirements of the notification in the electronic health record. The education included timely completion of an assessment of potential injury, incident reporting and 72-hour follow up & documentation after a resident incident. This education was completed by the Director of Nursing Services (DNS) and Executive Director (ED). This education was completed on 7/20/2018. Monitoring procedure to ensure POC is effective: An audit will be completed daily (Mon-Fri) by members of the facility QAPI Team (Administrator, MDS, & administrative nurse at a minimum). A report of all incidents will be obtained from our electronic clinical incident reporting system. This report will be cross referenced with resident medical record & 24- hour report to ensure proper nurse assessment, documentation and notification of resident□s attending physician and resident representative are documented in the medical record. This Audit will continue daily for 12 weeks, then 3 times a week for 12 weeks, and finally monthly for 3 months. A summary of audit results will be analyzed for patterns and trends and reported to the Quality Assurance Performance Improvement (QAPI) Team by the Director of Nursing Services for 3	

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F 580	Continued From page 3	F 580		

the RP had stated she was not notified until x-rays were done on Resident #3's left leg because there was some swelling present and when she inquired about the swelling she was told Resident #3's foot had been caught under her wheelchair the day before on 05/19/18.

A review of a nurse's progress note dated 05/20/18 at 6:27 PM revealed in part Nurse #1 had been notified that Resident #3's left leg got caught in a wheelchair while on her way to the main dining room. The notes further revealed on this date of 05/20/18 Resident #3's leg was swollen and she complained of pain when touched and the physician on call was notified and orders were received to obtain an x-ray of left tibia and fibula including the left ankle and foot.

A review of an x-ray report dated 05/20/18 indicated acute fracture of distal left tibia-fibula but no other boney pathology. The report further indicated left ankle x-ray revealed an acute non-displaced distal tibia and fibula fracture.

A review of a facility document titled Resident Grievance Form dated 05/21/18 indicated Resident #3's family was not called when Resident #3's foot was caught under her wheelchair.

During an interview on 07/06/18 at 8:56 AM, Nurse #2 stated she worked at the facility on the 7:00 PM to 7:00 AM shift on 05/19/18. She explained Nurse #1, who was also the weekend nursing supervisor had been assigned to a medication cart during the 7:00 AM to 7:00 PM shift on 05/19/18. She further explained during shift report on 05/19/18 Nurse #1 asked her to check Resident #3's legs because she had some

months, at which time, the QAPI committee will evaluate the effectiveness of the interventions to determine if additional auditing is necessary to maintain compliance.
Title of person responsible for implementing the plan: The Director of Nursing Services

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F 580	Continued From page 4	F 580		

swelling but did not report that Resident #3 had caught her foot under her wheelchair. Nurse #2 stated she checked Resident #3's legs and saw slight swelling in her left leg above the ankle and monitored Resident #3 during the night but the swelling did not increase. She further stated at that time she did not know an event had occurred with Resident #3 because there were no nurse's progress notes regarding the incident. She explained when she came back to work on 05/20/18 at 7:00 PM she asked Nurse #1 during shift report what had happened with Resident #3 and she said when NA #1 was pushing her in a wheelchair to the dining room on 05/19/18 Resident #3 got her foot caught under the wheelchair. Nurse #2 stated she called Resident #3's RP after they received x-ray results and Resident #3's RP asked why no one had called her about the wheelchair incident. Nurse #2 explained when an incident happened it was her usual practice to notify the resident's RP after the incident occurred.

During a phone interview on 07/06/18 at 9:37 AM, Nurse #1 stated she no longer worked at the facility but recalled the incident when Resident #3 got her foot caught under the wheelchair. She further stated she had gotten busy during her shift on 05/19/18 and had forgotten to call Resident #3's RP.

During an interview on 07/06/18 at 10:49 AM the DON stated she recalled Nurse #2 had called her on Sunday night on 05/20/18 and reported Resident #3 had a fracture. She explained during an investigation Nurse #1 reported she had not called Resident #3's RP after the incident because she got busy and forgot to call her. She further stated it was her expectation for the

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F 580	Continued From page 5 resident's RP to be notified after an incident occurred. During an interview on 07/06/18 at 11:29 AM, the Staff Development Coordinator explained when an incident occured the nurse would be expected to notify the resident's RP and document it in the resident's medical record.	F 580		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		7/31/18

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F 842	Continued From page 6 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the	F 842	F 842 - Resident Records □ Identifiable	

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F 842	Continued From page 7 facility failed to document a nursing assessment after a resident's left foot was caught under a wheelchair which later revealed a non-displaced distal fracture of the tibia and fibula for 1 of 4 sampled resident for supervision to prevent accidents (Resident #3). Findings included: Resident #3 was re-admitted to the facility on 06/27/16 with diagnoses which included kidney disease, Type 2 diabetes, osteoarthritis of left knee, osteoporosis, Alzheimer's disease, dementia, anxiety and depression. A review of a care plan with onset date of 02/01/18 revealed Resident #3 had a diagnosis of osteoporosis and was at risk for injury or fracture related to changes in bone structure and bone density. The goals indicated in part staff would implement interventions to maintain a safe environment daily to reduce risk for injury and interventions were listed in part Resident #3 was non-verbal and staff were to identify non-verbal indicators of pain or discomfort. A review of an annual Minimum Data Set (MDS) dated 04/22/18 indicated Resident #3 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #3 was totally dependent on staff for bed mobility, transfers and locomotion on and off the unit. A review of a facility document titled Occurrence Report completed by the Director of Nursing (DON) indicated on 05/19/18 at 5:00 PM an incident had occurred when Resident #3 was being transported in a wheelchair and her left foot	F 842	Information Plan for correcting the specific deficiency: 5/20/18, Nurse #1 did contact the resident RP and attending physician, reporting the resident change in condition, of increase swelling & pain noted of left leg. Order for x-ray was obtained and Nurse #1 documented x-ray results in the medical record for resident #3. Nurse #1 failed to timely document the nursing assessment that was completed on 5/19/2018. The root cause of this deficiency was human error by one staff member. Nurse #1 is no longer employed as of 5/23/18. Procedure for implementing the plan: The facility Administrator completed an audit of resident incidents and/or documentation for the previous 30 days to ensure nurse assessments were completed timely. This audit was completed as of July 9, 2018. Any corrections noted were corrected by the Nurse Managers by July 13, 2018. The facility Director of Nursing Services and Administrator re-educated licensed nurses regarding the facility□s policy and expectations for timely assessment of a resident, and documentation of that assessment, when a resident experiences an unplanned event. The training also addressed notification of attending Physician and resident representative after an incident of adverse outcome with a resident, and timely completion of an incident report of potential injury, and 72-hour follow up & documentation requirements after a resident incident. This education was completed on	

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F 842	Continued From page 8 was caught under the chair. A review of nurse's progress notes dated 05/19/18 revealed there was no documentation of a nursing assessment of Resident #3 after her left foot was caught under the wheelchair.. A review of a facility document titled Investigation Summary dated 05/20/18 indicated on 05/19/18 at approximately 5:00 PM, NA #1 was transporting Resident #3 to the dining room in her wheelchair when Resident #3 suddenly dropped her foot while NA#1 was pushing the wheelchair and Resident #3's foot was caught under the chair. The document further indicated Resident #3 called out and NA #1 immediately stopped the chair and told Nurse #1 what had happened. The document revealed Nurse #1 assessed Resident #3's leg and did not observe swelling at that time and Resident #3 did not complain of pain when she attempted range of motion. The document also revealed Nurse #1 stated she had gotten busy during the shift and had forgotten to document the incident. A review of a nurse's progress note dated 05/20/18 at 6:27 PM revealed in part Nurse #1 had been notified that Resident #3's left leg got caught in a wheelchair while on her way to the main dining room. The notes further revealed on this date of 05/20/18 Resident #3's leg was swollen and she complained of pain when touched and the physician on call was notified and orders were received to obtain an x-ray of left tibia and fibula including the left ankle and foot. A review of an x-ray report dated 05/20/18 indicated an acute fracture of distal left tibia-fibula but no other boney pathology. The report further	F 842	7/20/2018. Monitoring Procedure: An audit will be completed daily (Mon-Fri) by the facility QAPI Team (Administrator, MDS, & administrative nurse). A report of all incidents will be obtained from our electronic clinical incident reporting system. This report will be cross referenced with resident medical record & 24- hour report to ensure proper nurses assessment, documentation and notification of resident□s attending physician and resident representative are documented in the medical record. This Audit will continue daily for 12 weeks, then 3 times a week for 12 weeks, and finally monthly for 3 months. A summary of audit results will be analyzed for patterns and trends and reported to the Quality Assurance Performance Improvement (QAPI) Team by the Director of Nursing Services for 3 months, at which time, the QAPI committee will evaluate the effectiveness of the interventions to determine if additional auditing is necessary to maintain compliance. Title of person responsible for implementing the plan: The Director of Nursing Services	

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F 842	Continued From page 9	F 842		

indicated left ankle x-ray revealed an acute non-displaced distal tibia and fibula fracture.

During an interview on 07/06/18 at 8:56 AM, Nurse #2 stated she worked at the facility on 05/19/18 during the 7:00 PM to 7:00 AM shift. She explained Nurse #1, who was also the weekend nursing supervisor had been assigned to a medication cart during the 7:00 AM to 7:00 PM shift on 05/19/18. She further explained during shift report on 05/19/18 Nurse #1 asked her to check Resident #3's legs because she had some swelling but did not report that Resident #3 had caught her foot under her wheelchair. Nurse #2 stated she checked Resident #3's legs and saw slight swelling in her left leg above the ankle and monitored Resident #3 during the night but the swelling did not increase. She further stated she did not know an event had occurred with Resident #3 because there were no nurse's progress notes regarding the incident or assessment of Resident #3's left leg by Nurse #1. Nurse #2 explained when an incident happened it was her usual practice to document assessments in the nurse's progress notes.

During a phone interview on 07/06/18 at 9:37 AM, Nurse #1 stated she no longer worked at the facility but recalled the incident when Resident #3 got her foot caught under the wheelchair. She further stated she had gotten busy during her shift on 05/19/18 and had forgotten to write a nurse's progress note of her assessment of Resident #3's left leg.

During an interview on 07/06/18 at 10:49 AM the DON stated she recalled Nurse #2 had called her on Sunday night on 05/20/18 and reported Nurse #1 had reported NA#1 was transporting Resident

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F 842	Continued From page 10 #3 in a wheelchair but Resident #3 dropped her feet onto the floor and her left foot went under the wheelchair. She explained Nurse #1 did not document the incident at the time it occurred and did not document her assessment of Resident #3's leg because she stated she got busy and forgot to write it. She stated it was her expectation for nurses to document assessments of residents in the nurse's progress notes. During an interview on 07/06/18 at 11:29 AM, the Staff Development Coordinator explained when an incident occured the nurse would be expected to document assessments in a nurse's progress note.	F 842		