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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	05/03/2012

RECEIVED MAY 30 2012

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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, the facility failed to ensure the heating systems were clean and in good repair in resident (Rooms #102, 105, 110, 107, 112, 120, 205, 206, 210, 204, 207, 212,213, 214, 202, 308,301,217, 208, 306, 304, 311,313, 315, 317, 319, 413,409, 417,418,425, 423, 321,416, 212 and 203). . The findings included: During initial tour on 4/30/12 at 6:39PM, observations revealed broken grill tops and fronts: 1. Observation in room 102 heating system grill was broken. 2. Observation in room 105 heating system grill was broken 3. Observation in room 107 heating system grill was broken 4. Observation in room 110 heating system grill was broken 5. Observation in room 112 heating system grill was broken 6. Observation in room 120 heating system grill was broken 7. Observation in room 202 heating system grill was broken 8. Observation in room 203 heating system grill was broken	F 253	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the accuracy of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code Section 12909 and C.F.R. 405 1907.	
		F253	**For resident rooms cited** A. All in-wall heating systems (PTAC) in rooms cited were inspected for needed repairs and needed cleaning. Temporary repair of damaged grills was made and repair method demonstrated to surveyor who indicated approval of temporary repair. All PTAC units were cleaned and re-inspected by Plant Operation Director. B. For All rooms with broken grills: 1) in-house back-up supply grill replacements were installed or 2) replacement discharge or intake grills were purchased and installed or 3) for those units for which grills are not available, new units are being purchased and installed. C. Housekeeping staff was in-serviced regarding high vac procedures inclusive of cleaning of PTACs. **For All Residents** A. All other PTACs were inspected for repair status and cleanliness. All units were cleaned.	5/31/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — [signature] | TITLE — Administrator | (X6) DATE — 5/25/12

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 253	Continued From page 1 9. Observation in room 204 heating system grill was broken 10. Observation in room 205 heating system grill was broken 11. Observation in room 206 heating system grill was broken 12. Observation in room 207 heating system grill was broken 13. Observation in room 208 heating system grill was broken 14. Observation in room 210 heating system grill was broken 15. Observation in room 212 heating system grill was broken 16. Observation in room 213 heating system grill was broken 17. Observation in room 214 heating system grill was broken 18. Observation in room 217 heating system grill was broken 19 Observation in room 301 heating system grill was broken 20. Observation in room 304 heating system grill was broken 21. Observation in room 306 heating system grill was broken 22. Observation in room 308 heating system grill was broken 23. Observation in room 311 heating system grill was broken 24. Observation in room 313 heating system grill was broken 25. Observations in room 315 heating system grill was broken 26. Observation in room 317 heating system grill was broken 27. Observation in room 319 heating system grill was broken	F 253	B. For All rooms with broken grills: 1) In-house back-up supply grill replacements were installed or 2) replacement discharge or intake grills were purchased and installed or 3) for those units for which grills are not available, new units are being purchased and installed. B. Housekeeping staff was in-serviced regarding high vac procedures inclusive of cleaning of PTACs. **System Changes:** A. Policy for high vac cleaning was clarified to specify cleaning of PTACs and reporting of breakage or potential safety concerns to Plant Operations Director. B. Monthly PTAC audits initiated to include visual inspection of PTACs to check for cleanliness, damage and/or potential safety concerns. C. Monthly PTAC audit added to electronic preventative maintenance program "BIG FOOT." **Monitoring:** A. All PTACs will be inspected weekly x 1 month, bimonthly x 2, then monthly ongoing. B. Monthly PTAC audits will include visual inspection of through the wall units looking for cleanliness, damage and / or potential safety elements and repairs made as needed.	Date of 5/3/2012 5/3/2012 and ongoing Date of [illegible] Ongoing

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F 253	Continued From page 2 28. Observation in room 409 heating system grill was broken 29. Observation in room 413 heating system grill was broken 30. Observation in room 416 heating system grill was broken 31. Observation in room 417 heating system grill was broken 32. Observation in room 418 heating system grill was broken 33. Observation in room 423 heating system grill was broken 34. Observation in room 425 heating system grill was broken 35. Observation in room 321 heating system grill was broken. In addition, to the broken grills the 35 rooms the system also had a large volume of gray colored lint/dust built up dried food particles and white molded substances inside the vents. Follow-up observations were done of the resident rooms on 5/1/12 at 10:00AM, 5/2/12 at 11:58AM, and 5/3/12 at 8:00AM and 9:25AM, the heating system remained in the same condition. Several of the resident rooms had the heat blowing the dust from the system throughout the room. During an observation on 5/1/12 at 11:13AM, a resident was observed sticking her toe in the broken section of the front portion of the heating system. During an interview on 5/1/12 at 8:52AM, housekeeper #1(HK) indicated that resident room cleaning consisted of dusting resident furniture, vacuuming, cleaning bathroom, cleaning the outside of the heating system, emptying trash.	F 253	C. The results of these audits will be discussed monthly QA meeting for three months by the facility Quality Assurance Committee for compliance and, as needed, any further action.	

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F 253	Continued From page 3 Housekeeping supervisor and maintenance was responsible for repairs to the system. In addition, any staff should report broken pieces on the heating system to maintenance or fill out work order sheet. During an interview on 5/3/12 at 8:30AM, HK #2 indicated that the house keeping staff rotate as the vacuum person. Resident room cleaning consist of bathrooms, dust/mop/vacuum floors, night stands/tables, trash. Maintenance was responsible for cleaning the vents inside the heating/air conditions and housekeeping wipes down fronts and tops. She added the high vacuum person was responsible for cleaning the window sills, vacuum around doors and sprinkles and vacuum under bed. The expectation was to report anything that needs repairs in resident rooms to maintenance. In addition, she had not cleaned the heating/air condition. During an interview on 5/3/12 at 8:45AM, HK #3 indicated that the two house keepers rotate as housekeeper and vacuum staff. She added that resident room cleaning included the bathrooms, dust/furniture, vacuum/mop floors, trash and fronts/tops of heating systems. She indicated that she had not cleaned the heating/air systems. The items that are broken in resident rooms should be reported to maintenance. She added that the tops/fronts of heating/air system been broken for awhile. During an interview on 5/3/12 at 8:45AM, the Floor Tech indicated that his responsibility was for mopping/ buffing, offices, common areas. Maintenance was responsible for cleaning heating/air system. Vacuum person and	F 253		

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F 253	Continued From page 4 maintenance was expected to clean those on a weekly basis. During an interview on 5/3/12 9:00-9:25AM, the maintenance director indicated that he had 2 HK 7:00AM-3:30Pm, 1 Vacuum Person 7:00AM-11:00AM, 1 Floor Tech and 1 Laundry person on 1st shift. On 2nd shift 1 laundry 4:30PM to 1:00AM to handle the housekeeping/laundry needs of the building. There was no assigned staff on 3rd shift. Tour of the rooms included observing resident rooms with dirty heating/air systems and/or broken grill fronts and tops. The maintenance director wiped his hand across several of the fronts and tops of the system and acknowledged that they needed cleaning and the grills fronts/tops needed to be repaired. During an interview on 5/3/12 at 10:15AM, the administrator indicated that the housekeeping staff should perform the high dusting procedure which included cleaning and dusting of the heating/air systems. Maintenance should be monitoring and cleaning the systems at least weekly and periodical checks to ensure proper cleaning was being done and rounds should be done to ensure the systems were in good repair.	F 253		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 - Part 1 For residents cited: Due to the nature of this deficiency individual residents were not cited.	5/9/12

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F 371	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review,1. the facility failed to maintain sanitary conditions in the kitchen by not ensuring opened and resealed food items were dated and labeled in 1 of 1 walk in refrigerator; 2. the facility failed to keep produce food wholesome in 1of 1 walk in refrigerator; 3. the facility failed to ensure food service equipment was clean and free from debris; 4. facility failed to remove dented cans from ready to use food items; 5. the facility failed to air dry coffee cups/water glasses(38), 74 salad bowls and 3 serving pans; 6. the facility failed to remove boxes of ice cream off the floor in the main kitchen area and 7. the facility failed to ensure the kitchen floor was free from excess water. Findings included: 1.During an observation of the walk in refrigerator on 4/30/12 at 6:45PM, several items were located on the refrigerator shelves in small sandwich bags opened, unlabeled and/or undated. The items were opened and exposed to other refrigerated items. The following items were in opened sandwich bags and/or unlabeled, tator tots dated 4/8/12, 2 bags of shredded carrotts, 1 bag of red shredded cabbage opened unlabeled or dated in sandwich bag, 1 bag of opened red cabbage dated 4/20/12, 1 onion wrapped in seran wrap undated or labeled, 1 sandwich bag of	F 371	**For all residents:** The facility will maintain sanitary conditions in the kitchen by ensuring that all food items are properly labeled and dated in the walk-in cooler. A. All effected food that was not labeled and dated was discarded immediately. B. The Area Manager (Certified Dietary District Manager - CDDM) re-in-serviced staff on proper labeling and dating procedures on (5/1/12). C. Vice President of Operation re-in-serviced staff on proper procedure for label and dating (5/8/12). **System Changes:** Cook Supervisors will conduct and document Daily Opening Sanitation Walk Through and a Closing Checklist ensuring that all items are properly labeled and dated. These items are specified on the cook's checklist. **Monitoring:** A. The Food Service Director (FSD. will do random spot checks twice daily to ensure compliance and take corrective action as needed. B. The FSD will monitor compliance and accuracy of the Opening and closing checklist daily. C. The Area Manager will monitor the Opening and closing checklist weekly. D. The Area Manager will conduct a Food Safety Unit Audit daily x 2 week; twice weekly x 2 weeks, weekly x 4 weeks, twice monthly x 1 month, then unannounced monthly ongoing. **Part 2** **For residents cited:** Due to the nature of this deficiency individual residents were not cited.	5/8/12

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F 371	Continued From page 6 opened grated cheese dated 4/18/12, 1 bag of openned parmesan cheese dated 4/18/12, quarter squares of yellow slice cheese wrapped in seran wrap unlabeled or dated. During an interview on 4/30/12 at 6:45PM, the Certified Dietary District Manager(CDDM) indicate that open products like cheese, carrots should be used within three days of being opened and dated/labeled. Staff should be checking the refrigerator daily to ensure there was no spoiled food. Staff was aware and in-serviced that open foods should be dated/labeled immediately and used within a few days. CDDM indicated the white substance in the open bag was parmesan and grated cheese. She also indicated that the torn opened bag of parsley should have been replaced in another sealed bag and dated. 2. During an observation on 4/30/12 at 6:45PM, the following produce was observed spoiled or rotten in the walk in refrigator 1 bag of opened undated or labeled parsley with rotting leaves and stalks. The parsley was located in a large box on the shelve on top of other produce of green and red peppers. On the refrigerator shelf in a stainless steal pan 5 red peppers, 1 red pepper were spoiled and rotten in the pan with milky white substance. In addition, there was 1 bag of mushy spoiled cuccumbers in a sandwich bag also on the refrigerator shelf. There was an odor from the spoiled peppers and the cuccumbers. During an interview on 4/30/12 at 6:45PM, the CDDM indicate that open products like cheese, carrots should be used within three days of being opened and dated/labeled. Produce like peppers should be used within 1 week of delivery date. Staff should be checking the refrigerator daily to ensure there was no spoiled food. Staff was aware and in-serviced that open foods should be	F 371	**For all residents:** The facility will keep produce wholesome in the walk-in refrigerator. A. All produce that was spoiled was immediately discarded. B. All dietary staff was in-serviced to visually inspect produce before use and discard all spoiled and tainted produce at the first sight of spoilage. **System Changes:** A. Order produce in smaller quantities to reduce spoilage. B. Keep red onions in cooler instead of storeroom C. Any cut produce that has not been used after 3 days must be discarded. The Area Manager in-serviced staff on this concern on 5/1/12. The Vice President of Operation in serviced staff on 5/8/12. D. Cook Supervisors will conduct an Opening Sanitation Walk Through and a Closing Checklist daily to ensure that there is no spoiled or out of date produce. Trends will be documented and reviewed with FSD and Area Manager. **Monitoring** A. The FSD will monitor the Opening and closing checklist daily, spot checking for compliance. B. The Area Manager will monitor the opening and closing checklist weekly. C. The Area Manager will conduct a Food Safety Unit Audit daily x 2 week; twice weekly x 2 weeks, weekly x 4 weeks, twice monthly x 1 month, then unannounced monthly ongoing. **Part 3** **For residents cited:** Due to the nature of this deficiency individual residents were not cited. **For all residents:** The facility will ensure that all food service equipment is clean and free of debris. A. The slicer was cleaned immediately after use.	5/2/12

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F 371	Continued From page 7 dated/labeled immediately and used within a few days. CDDM also acknowledged the spoiled produce in sandwich bags and stainless steal pan. During a second observation on 5/2/12 at 10:56AM, in the dry storage area there was a large box of red onions dated 4/18/12, several rotten onions mixed in with good onions. During an interview on 5/2/12 at 10:56AM, the stock person indicated that a visual check should have been done of the onions when they arrived and remove the bad onions. The CDDM observed the several rotten onions and stated that a visual inspections should be done and the rotten ones would be disposed of prior to use. CDDM discarded the whole box without checking for the ones that were good. 3. During an observation on 4/30/12 at 6:45PM, the slicer blade and in between the crevices was on the work station table in the back of the kitchen with a white substance. During a second observation 5/2/12 at 10:45AM, the white substance remained on the slicer blade and crevices. During an interview on 5/2/12 at 10:45AM, CDDM confirmed the white matter on slicer was cheese that was sliced during the earlier part of the day. 4. During an observation on 4/30/12 at 6:45PM, in the dry storage area several dented cans were observed on a rack. The following cans were observed 2 large cans of hash browns, 4 large cans sauerkraut, 2 cans of red kidney beans, 2 large cans of tomatoes and 1 can of pinto beans. On the dry product shelf 2 boxes of opened carton of mashed potatoes. During an interview on 4/30/12 at 6:45PM, the CDDM indicate that dented cans should not be stored in dry storage and should be returned to	F 371	**System Changes:** The Area Manager rein-serviced staff on the proper procedure for cleaning the slicer, sanitizing the slicer immediately after each use, and the requirement to keep the slicer covered between each use. The FSD will inspect slicer for cleanliness and proper storage after each meal prep during which the slicer is utilized. **Monitoring:** A. On all days that the slicer is used in food prep the Food Service Director will inspect the slicer after it has been clean and sanitized and before slicer is covered for day. Outcome of inspection will be documented on the Daily Sanitation Walk Through. B. The Area Manager will conduct a Food Safety Unit Audit daily x 2 week; twice weekly x 2 weeks, weekly x 4 weeks, twice monthly x 1 month, then unannounced monthly ongoing. **Part 4** **For residents cited:** Due to the nature of this deficiency individual residents were not cited. **For all residents:** The facility will remove and keep all dented cans separate from ready to use food products. A. All dented cans were immediately removed to manager's office for processing and then discarded. B. Area Manager re-in-serviced staff regarding the proper procedure for receiving and disposing of dented cans. 5/1/12. C. Vice President of Operations re-in-serviced staff on the proper procedure for receiving and disposing of dented cans on 5/8/12.	5/9/12

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F 371	Continued From page 8 vendor. During a second observation on 5/2/12 at 10:56AM, the stock person was observed stocking dented cans on the shelf with other cans. The can rack was rechecked and there were 3 cans of tomatoes on the rack and on the floor there were 5 more dented cans of tomatoes. During an interview on 5/2/12 at 10:56AM, the stock person stated that he was suppose to check cans by touching them. 5. During an observation on 5/2/12 at 10:45AM, 3 of 6 silver serving pans stacked wet. During an interview on 5/2/12 at 10:45AM, CDDM indicated that stafff was expected to dry all pans and dishes prior to storing them on dry racks. There should be no pans stacked wet. The CDDM asked her staff who stacked the dishes and pans wet and all responded they were unaware of who stacked the wet dishes or pans. During a second observation on 5/2/12 at 4:05PM, 38 coffee/clear cups were wet stored in crates on a dolly, 74 salad bowls wet and stored on top of one another in a crate.The water was draining from one crate to another onto the dishes. During an interview on 5/2/12 at 4:05PM, the CDDM indicated that she was unaware that the cups/bowls could not be stored in crates until they were ready to be used. She added the cups/bowls were cleaned and ready to be used by the time they were used at the tray line they would be dry enough. 6. During an observation on 5/2/12 at10:42AM, four boxes of orange/ cherry ice cream pops 1box open on floor, 3other boxes on floor by exit door. The ice cream was soft and melting. During an interview on 5/2/12 at 10:45AM, CDDM indicated that the boxes should not have been on	F 371	**System changes:** A. New stock person started on 5/9/12. B. New stock person trained on proper stocking procedures. B. The closing cook will visually inspect all canned goods at end of shift and document compliance on the Closing Check List. Any dented cans found are discarded and labels from cans turned into FSD for processing. **Monitoring:** A. The FSD will do daily random spot checks of the storeroom. B. The FSD will monitor the closing checklist for accuracy take appropriate action. C. The Area Manager will monitor and spot check the Opening and closing checklist weekly. D. The Area Manager will conduct a Food Safety Unit Audit daily x 2 week; twice weekly x 2 weeks, weekly x 4 weeks, twice monthly x 1 month, then unannounced monthly ongoing. Part 5 **For residents cited:** Due to the nature of this deficiency individual residents were not cited. **For all residents:** Facility will allow all coffee cups, bowls, water glasses (small-ware), serving pans, and all other dishes to properly air dry. A. The Area Manager in-serviced the staff on the proper procedure for allowing for all dishes, pots, and pans to air dry on 5/2/12. B. The Vice President of Operations in-serviced all staff on the proper procedure for allowing all dishes, pots, and pans to air dry on 5/8/12.	5/8/12

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F 371	Continued From page 9 the floor and that she was going to throw them out, but got side tracked. 7. During an observation on 5/2/12 at 4:05PM, there was excessive standing water on the floor in the dish room and behind the oven and steamer area. During an interview on 5/2/12 at 4:05PM, the CDDM indicated that there had been a problem with dish machine and the technician had visit the week before to address the water in the dish room area. However, she was unable to explain the water behind the oven area.	F 371	**System changes:** A. Allow small-ware to stay on the drain board until they are completely dry. The dollies are not to be used for drying. B. Allow pots/pans to stay of drying rack until completely dry. **Monitoring:** A. The FSD will conduct daily random spot checks for compliance and document on the Daily Sanitation Log . B. The Area Manager will conduct Food Safety Audit daily x 2 week; twice weekly x 2 weeks, weekly x 4 weeks, twice monthly x 1 month, then unannounced monthly ongoing. **Part 6** **For residents cited:** Due to the nature of this deficiency individual residents were not cited. **For all residents:** The facility will not keep any food on the floor at any time. A. The orange/cherry pops which were set out to be discarded were discarded immediately. **System changes:** Boxes of food that are intended for disposal must be taken to the dumpster immediately. The Vice President of Operation in-serviced the staff that there is to be no food on the floor at any time and that food being discarded is to either be put in a trash bin or on a cart for disposal or taken directly to the dumpster. **Monitoring:** A. The FSD will monitor for compliance and document on the Daily Sanitation Walk Through. B. The Area Manager will conduct Food Safety Audit daily x 2 week; twice weekly x 2 weeks, weekly x 4 weeks, twice monthly x 1 month, then unannounced monthly ongoing.	5/8/12

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 ______	05/03/2012

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345535	A. BUILDING 01 - MAIN BUILDING B. WING	06/01/2012

RECEIVED JUN 18 2012 CONSTRUCTION SECTION

NAME OF PROVIDER OR SUPPLIER: ADAMS FARM LIVING & REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE: 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
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: A. Based on observation on 06/01/2012 the following doors failed to latch when closed a. 110 b. 317 c. 300 hall bath 42 CFR 483.70 (a)	K 018	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the accuracy of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code Section 12909 and C.F.R. 405 1907. **K018** **For resident rooms cited:** For all rooms listed, 110, 317, 300 hall bath, door latching mechanism will be adjusted, repaired and tested to assure proper latching. **For All Residents:** All residents room doors, resident baths and other facility interior doors will be tested. All door which failed to latch properly will be adjusted or repaired and proper latching verified. All facility staff will be educated related to need for doors to latch securely and how to report poorly latching doors to maintenance. **System Changes:** PM will be developed to cover checking of all doors for appropriate latching. All interior doors will be checked quarterly and documented on the periodic maintenance (PM) report. All doors failing to latch properly will be adjusted parts replaced as needed. **Monitoring:** PM for door latching will be completed monthly times 3 months, then quarterly. Outcome will be reported and discussed quarterly at Quality Assurance Committee meeting and, as needed, further action taken.	6/20/2012
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 6/15/12

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.

PRINTED: 06/04/2012
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	345535	A. BUILDING 01 - MAIN BUILDING B. WING	06/01/2012

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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K 029	Continued From page 1 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 06/01/2012 the kitchen dry storage room door failed to close and latch and the soiled linen room door was wedged in the open position. 42 CFR 483.70 (a)	K 029	K029 **For Deficiency Cited and All Residents** The kitchen dry storage room door was adjusted to assure proper closing. The housekeeping and laundry staff will be re-educated on requirements to keep the soiled linen room door closed; that door is never to be wedged open; and not to otherwise hold door open unless being immediately used to enter or leave. **System Change:** Life Safety requirement and reasoning for appropriate door closure will be added to housekeeping staff orientation as well as to quarterly fire drill inservicing. **Monitoring:** Unscheduled observations will be recorded 3 times a day times 2 weeks, then 2 days weekly x 2 weeks, then randomly 3 times a week x 2 months. Re-education and disciplinary action will action will be given as needed. Outcome will be reported and discussed quarterly at Quality Assurance Committee meeting and, as needed, further action taken.	6/29/2012
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 06/01/2012 there is an exit sign in the Activity Room on the 500 hall that leadsinto the court yard. once in the court yard you can not reenter the building and there is not hard surface pathway to the public way. 42 CFR 483.70 (a)	K 038	K038 **For Deficient Practice and All Residents:** Per conversation with Mr. Curtis Daniels, Engineer, Bilding System Engineer, Construction Section, DHSR, Adams Farm Living respectully requests temporary waiver to accommodate construction planning and labor. See letter attached. **System Change:** See above. **Monitoring:** See above.	9/16/2012
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050		

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	345535	A. BUILDING 01 - MAIN BUILDING B. WING	06/01/2012

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K 050	Continued From page 2 that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: A. Based on Observation on 06/01/2012 the staff interviewed did not know the fire drill procedure. 42 CFr 483.70 (a)	K 050	**K050** **For Deficient Practice and All Residents** All facility staff will participate in a "Red Flame" campaign which will consist of group education of fire drill procedures, do's and don'ts and wheres and hows. All staff will be tested on classroom education and then will be required to individually demonstrate competence by return demonstration of RACE procedure. **System Changes:** RACE education with testing will be added to orientation. **Monitoring:** Each month at non-scheduled times, 3 random staff members from random departments will be selected to individually demonstrate RACE competency. Anyone failing competency test will be re-educated. Outcome of fire drills and competency testing will be reported and discussed quarterly at Quality Assurance Committee meeting and, as needed, further action taken.	6/29/2012
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 06/01/2012 the facility must have an system flush as a result of a failed flow test B. The facility did not have documentation the show the time of water arrival to the inspecters test orfice. 42 CFR 483.70 (a)	K 062	**K062** **Deficiency Cited and All Residents:** Facility has two systems. System 1 passed but will be flushed per recommendation (6/12/12). Sytem 2 failed and will be flushed. Successful flushing validates correction of deficiency. **System Changes:** Annual inspection will include flushing of system for 2 years and then return to routine inspection and flushing schedule as required by code. **Monitoring:** Monitoring by outside contractor per NCPA 25.	6/12/2012

Adams Farm
LIVING & REHABILITATION

5100 Mackay Road · Jamestown, NC 2728

June 15, 2012

Curtis Daniel, Engineer
Building System Engineer
NCDHHS
Division of Health Service Regulation - Construction Section
2705 Mail Service Center
Raleigh NC 27699-2705

Reference: Deficiency K 038 of Annual Life Safety Survey June 1, 2012

Dear Mr. Curtis:

Per your conversation with Richard Coble, Plant Operations Director, Adams Farm Living and Rehabilitation, we are respectfully requesting a temporary waiver through September 16, 2012, for the above referenced deficiency. This temporary waiver will allow Adams Farm time to plan the corrective action for both the entry into the courtyard from the 500 Hall Activity Room and the required hard surface pathway to the public way, and therefore meet standard requirement.

Your consideration of this request is appreciated.

Sincerely,

Patti Anderson, Administrator