

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2025
NAME OF PROVIDER OR SUPPLIER  Adams Farm Living & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  5100 MacKay Road Jamestown, NC 27282	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide and implement an infection prevention and control program.  (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, record reviews and staff interviews, the facility failed to implement their policy for Enhanced Barrier Precautions (EBP) when Nurse Aide (NA) #3 failed to don a gown and gloves before providing oral care for Resident #2 who was under EBP for wounds and an indwelling catheter. The deficient practice occurred for 1 of 5 staff members observed for EBP (Nurse Aide #3). Findings included: The facility's Enhanced Barrier Precautions (EBP) policy dated 5/13/2023 revealed it was the policy of the facility to utilize Enhanced Barrier Precautions (EBP), an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employs targeted gown and gloves used during high contact resident care activities. Enhanced Barrier Precautions were indicated for high contact care activities for residents with wounds or indwelling medical devices including central lines and gastrostomy feeding tubes and required hand hygiene before and after leaving the room and the use of gloves and a gown. Observation of Resident #2's room on 12/2/25 at 2:58 PM revealed there was signage outside the room indicating Enhanced Barrier Precautions (EBP) were to be used. The room was a semi-private room and both residents in the room were on EBP. A blue Enhanced Barrier Precautions (EBP) sign was noted outside Resident #2's door on 12/2/25 at 2:58 PM. The sign read in part, STOP Enhanced Barriers. Everyone must clean hands before entering and after leaving the room. All healthcare personnel must wear gown and gloves for the following High Contact Resident Care Activities which include: dressing, bathing/showering, transferring, changing linens, provide hygiene, changing briefs or assisting with toileting, and device care or use; central lines, urinary catheter, feeding tubes, tracheostomy, wound care: any skin opening requiring a dressing. An observation was conducted with Nurse Aide #3 on 12/4/2025 at 9:20 AM in Resident #2's room. NA #3 entered Resident #2's room with a blanket and items to provide oral care. NA #3 draped a blanket over Resident #2 without gloves or a gown. NA #3 began providing oral care on Resident #2 and had a mask and gloves on without a gown. The NA was stopped by the surveyor and asked to place a gown on. Interview conducted with NA #3 on 12/4/2025 at 9:22 AM revealed she was assigned to Resident #2 for the morning shift. Interview included questions about the EBP for Resident #2 and NA #3 stated, I was rushing and I know better. NA #3 further revealed I got two out of three correct with my mask and gloves on. NA #3 stated she received training on the computer and by the Infection Preventionist regarding Enhanced Barrier Precautions. An interview was conducted with the Director of Nursing (DON) on 12/2/2025 at 4:00 PM. The DON stated EBP was only needed when there was a high contact care activity being performed on residents. The DON defined high activity care for residents as being wound care, activities of daily living care, ambulation, and gastrostomy care. She stated if staff were just answering a call light or changing the tube feeding you would not need full personal protective equipment (PPE) for EBP. The DON stated she expected all staff to follow infection control policy for EBP and to identify the posting of the EBP signs on the residents' doors. An interview with the Administrator on 12/3/2025 at 1:44 PM revealed she was aware Resident #2 was on EBP. The Administrator stated residents who require EBP are those who have wounds, have a urinary catheter, tracheostomy, and gastrostomy tube. She said the staff do not need to have PPE on when entering a resident room on EBP to answer their call light. The Administrator stated any residents on EBP would have a sign posted on their door and any staff member physically providing hands on care for the resident was expected to have a gown and gloves on. The Administrator stated the nursing staff were educated regarding Enhanced Barrier Precautions through in-person and on-line in-services. The Administrator stated the NA should have worn a protective gown and gloves while performing oral care to Resident #2.</p>		