STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345167	A. BUILDING _____ B. WING _____	C 09/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN NURSING CARE CENTER	903 W MAIN STREET BOX 879 YADKINVILLE, NC 27055

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F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280		10/25/17

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

Electronically Signed | 10/18/2017

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F 280	Continued From page 1 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 280		

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F 280	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews, the facility failed to revise a pressure ulcer care plan for 2 of 2 sampled residents (Resident #3 and #4) with a pressure ulcer that became infected with MRSA (Methicillin Resistant Staphylococcus Aureus). Findings included: 1. Resident #3 was admitted to the facility on 9/2/14 with diagnoses that included Alzheimer's dementia and delusional disorder. A review of the most recent MDS (Minimum Data Set) dated 8/25/17, coded as an annual assessment, had documentation of Resident #3 being assessed as having impaired cognition. The assessment was coded as resident needing extensive assistance with activities of daily living, and having one unstageable pressure ulcer. A review of the resident's lab results revealed the wound culture result dated 9/7/17 had documentation that the culture was positive for MRSA. A review of the resident's active care plan last reviewed on 8/1/17, had a care plan in place for a pressure ulcer. No revisions were made after the pressure ulcer became infected with MRSA. 2. Resident #4 was admitted to the facility on 2/12/13 with diagnoses that included cerebral vascular accident (CVA), diabetes, and neuropathy. A review of the most recent MDS dated 9/1/17, coded as a quarterly assessment, had	F 280	F280 STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Resident #'s 3 and 4 have negative cultures for MRSA as of 10/17/2017 and 09/29/2017, respectively. For those residents having the potential to be affected by the same alleged deficient practice, the MDS Coordinator has reviewed all Care Plans for residents who have pressure ulcers with active infections, specifically cultures remarkable for MRSA to ensure the care planning interventions/approaches are updated to reflect any infection(s). Such audits were completed on 10/9/2017. To complete the task, the MDS Coordinator shall reconcile the Care Plans for all residents currently care planned for pressure ulcers against the facility's record of residents with pressure ulcers for the most recent 6 months. Any resident's Care Plan found to be lacking an update related to the interventions related to an active wound infection shall be updated to include any new interventions. Additionally, the MDS Coordinator was in-serviced on 10/2/2017 on the importance of updating resident's	

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F 280	Continued From page 3 documentation of Resident #4 as cognitively intact and required extensive assistance with activities of daily living. The assessment was coded as resident having one Stage 3 pressure ulcer to the sacral region. A review of a consultation note written by the Nurse Practitioner on 9/14/17 for Resident #4 read: worsening wound with MRSA/bacteroides infection to Stage 3 pressure ulcer at sacrum. A review of the resident's active care plan last reviewed on 9/1/17, had a care plan in place for a pressure ulcer. No revisions were made after the pressure ulcer became infected with MRSA. An interview was conducted on 9/27/17 at 12:58pm with the MDS Coordinator. The MDS Coordinator indicated the care plan was a reference for anyone providing care and both Resident #3 and Resident #4 should have been care planned for an infection with MRSA. An interview was conducted on 9/27/17 at 3:17pm with the DON (Director of Nursing). The DON revealed it was her expectation that infections were to be care planned.	F 280	care plans by revising any interventions/approaches related to infections of wounds consistent with available educational information pursuant to the CDC guidelines and the facility's infection control policy(ies). Training related to the CDC guidelines was completed on 9/29/2017 and 10/13/2017. The training was completed by the Infection Control Nurse and the Director of Nursing. The MDS Coordinator shall present the findings and subsequent plan of correction for this alleged deficient practice to the facility's Quality Assurance Committee. Furthermore, the MDS Coordinator shall report to the Committee any identified discrepancies no less than monthly for three months, and quarterly thereafter.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and	F 441		10/25/17

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communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 441	Continued From page 5 contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, policy review, record reviews, staff interviews, Nurse Practitioner interview and physician interview, the facility failed to implement contact isolation precautions for 2 of 2 sampled residents (Resident #3 and #4) that had a diagnosis of MRSA (Methicillin Resistant Staphylococcus Aureus) and failed to perform hand washing after removing gloves during incontinence care for 1 of 1 sampled resident (Resident#4). Findings included: A facility policy titled "Isolation and Infection Precautions" dated and revised on 1/01 states Isolation and Infection Precautions are implemented in accordance with CDC (Centers for Disease Control) and Prevention guidelines. 1. Resident #3 was admitted to the facility on 9/2/14 with diagnoses that included Alzheimer's	F 441	F441 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Resident #'s 3 and 4 have negative cultures for MRSA as of 10/17/2017 and 09/29/2017, respectively. Accordingly, Resident #'s 3 and 4 do not require infection control precautions beyond standard universal precautions. For those residents having the potential to be affected by the same alleged deficient practice, all nursing staff have been in-serviced on proper isolation	

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F 441	Continued From page 6 dementia and delusional disorder. A review of the most recent MDS (Minimum Data Set) dated 8/25/17, coded as an annual assessment, had documentation of Resident #3 being assessed as having impaired cognition. The assessment was coded as resident needing extensive assistance with activities of daily living, and as having one unstageable pressure ulcer. During a review of the resident's physician orders, an order dated 9/1/17 read: wound culture for left foot/heel wound times one. A review of the resident's lab results revealed the wound culture result dated 9/7/17 had documentation that the culture was positive for MRSA. Further review of the physician orders revealed a clarification order dated 9/8/17 that read: Doxycycline 100 mg (milligrams) by mouth twice daily for 14 days; wound consult. An observation on 9/26/17 at 10:41am of Resident #3's room revealed there was no signage on the door to indicate the resident was on any type of precautions. During an interview on 9/27/17 at 9:24am with Nurse #1 that completed the dressing change for Resident #3, she stated there were no residents on Hall 600 (Resident #3 resided on the 600 Hall) with any infections or on isolation. An additional interview was conducted on 9/27/17 at 9:59am with Nurse #1 and she indicated that she had misspoken about Resident #3 earlier regarding having an infection. Nurse #1	F 441	precautions and proper infection control procedures, including good hand washing practices. The education provided is consistent with current CDC guidelines and the facility's infection control policy(ies). Additionally, the Director of Nursing reviewed the facility's current record of active infections on 9/28/2017 and determined no current residents require contact isolation precautions as of 10/18/2017. To ensure compliance beginning on 9/28/2017, the Infection Control Nurse or their designee shall complete a Contact Isolation Report daily for two weeks and weekly thereafter. The report shall identify any resident requiring contact isolation precautions and shall also include whether signage is needed in order to alert staff and visitors to the need for contact isolation precaution(s). Such determinations shall be made pursuant to current CDC guidelines related to contact isolation and the facility's infection control policy(ies). The Infection Control Nurse received training at the Spice Program in September 2017. The infection control nurse has in-serviced the Spice Program recommendations, facility polcy(ies) and the recommendations of the CDC on 9/28/2017, 9/29/2017 & 9/30/2017. Beginning on 10/4/2017, the Infection Control Nurse or their designee began reporting infections requiring contact isolation procedures to the Quality Assurance Committee weekly for four weeks (10/4, 10/11, 10/18 &	

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F 441	Continued From page 7 continued to explain that Resident #3 did in fact have an infection, MRSA in the wound and strict handwashing was performed and gloves were to be worn while providing care. Another observation on 9/27/17 at 10:21am for Resident #3's room revealed there was no signage on the door to indicate the resident was on any type of precautions. 2. Resident # 4 was admitted to the facility on 2/12/13 with diagnoses that included cerebral vascular accident, diabetes, and neuropathy. A review of the most recent MDS dated 9/1/17, coded as a quarterly assessment, had documentation of Resident #4 as being cognitively intact and required extensive assistance with activities of daily living. The assessment was coded as resident having one Stage 3 pressure ulcer to the sacral region. A review of the Resident's physician orders revealed an order dated 9/4/17 that read: wound culture on coccyx. A review of a consultation note written by the NP (Nurse Practitioner) on 9/14/17 for Resident#4 read: worsening wound with MRSA/bacteroides infection to stage 3 pressure ulcer at sacrum. The NP further indicated she was unaware that the CDC recommended implementation of contact precautions to be initiated for a resident with MRSA in a wound residing in a long term living facility. Further review of new orders dated 9/14/17 from the Wound Care Specialist revealed a MRSA Protocol was started that included Bactroban 2%	F 441	10/25/2017)and will continue to report infections requiring contact isolation procedures to the Quality Assurance Committee monthly thereafter.	

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ointment ordered to be applied to each nostril with Q-tip just inside the nose and fingertips twice daily for 5 days and Hibi-Clens ordered to wash Resident #4 from head to toe daily for 14 days, and then to be used once weekly.

An observation on 9/26/17 at 11:16am of Nurse #2 during a pressure ulcer dressing change revealed no Contact Precautions signage on the door of Resident #4. During the dressing change Resident #4 had a bowel movement and assistance was called. The new covered dressing was removed and NA (Nursing Assistant) # 1 and NA #2 performed incontinent care. It was noted that after the incontinent care was provided, NA #2 took off her dirty gloves in the bathroom, put on new gloves without washing her hands, and then returned to the resident to assist NA #1 with positioning while Nurse #2 completed the wound care for Resident #4.

An interview was conducted on 9/26/17 at 2:31pm with NA #2. NA #2 indicated she had not washed her hands after she provided incontinence care for Resident #4 before putting on new gloves to continue care. The NA #2 revealed she was unaware of any precautions needed for any of the residents on Hall 100 including Resident #4. She recalled Resident #4 getting washed every morning by NA #1 with a soap for 14 days because of a skin infection but she did not know what kind of infection.

An interview was conducted on 9/26/17 at 2:57pm with a PSA (Personal Services Assistant) who helped during Resident #4's dressing change. The PSA indicated she was unaware of any precautions or infections on her assignment. She continued to explain that she read her Care

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Sheet on the hall before each shift about her assigned residents and would know if there were any precautions needed.

An interview with NA #1 was conducted on 9/26/17 at 3:05pm. NA #1 stated, "No one is on precautions on my hall today." NA #1 indicated Resident #4 had a skin infection but did not know what kind of an infection. She stated that she washed Resident #4 with Hibi-Clens every morning and would continue for 14 days with Friday being the 14th day.

An interview with Nurse#2 was conducted on 9/26/17 at 3:43pm. Nurse #2 stated Resident #4 was not on precautions but had MRSA in the wound. She stated the Nurse on the hall communicated with the staff about precautions. She indicated the Culture& Sensitivity(C&S) Report was the only written documentation regarding an infection.

An interview was conducted on 9/26/17 at 4:08pm with NA #3. NA #3 revealed he was the NA Preceptor for shift 3-11pm. He indicated contact precautions were not listed on the Care Sheets. He continued to explain if someone had MRSA they would be told by the nurses. NA #3 further indicated that nothing was written and there was only verbal communication in regards to precautions due to HIPPA (Health Insurance Portability and Accountability) laws.

An interview was conducted with the Physician on 9/27/17 at 1:11pm. He confirmed that he was the attending physician for both Resident #3 and Resident #4. The Physician stated that if a resident had MRSA with a "nasty, open wound", he would start Contact Precautions so that

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whoever was doing the dressing was aware and would be able to protect themselves and not spread the infection. He continued to explain, considering Resident #4 was receiving Hibi-Clens for 14 days and was treated in her nares, it was logical to start Contact Precautions.

An interview was conducted with the SDC/ICP (Staff Development Coordinator/ Infection Control Preventionist) on 9/27/17 at 2:05pm. She confirmed the Infection Control Policy related to precautions stated to follow CDC guidelines for LTCFs. She further stated in the future she would collaborate with Physicians and/or NP to determine precautions. The SDC/ICP further indicated her expectations for the staff regarding hand washing, was to wash their hands each time gloves were removed.

An interview was conducted with the NP on 9/27/17 at 2:07pm. The NP revealed she managed the care for Resident #3 and Resident #4. After reviewing the CDC guidelines, the NP stated, "Yes Contact Precautions should have been started based on the wound care and health in general for both residents."

An interview was conducted on 9/27/17 at 3:19pm with the DON (Director of Nursing). She stated it was her expectation for staff to wash their hands any time they take off their gloves. The DON indicated there was a potential for everything when discussing the spread of MRSA in a facility and would read the CDC guidelines to make changes as needed immediately.