	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
			A. BUILDING		C		
		345167	B. WING		11/21/2019		
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE			
			903	W MAIN STREET			
	URSING CARE CENTER		YAI	DKINVILLE, NC 27055			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC		
E 000	Initial Comments		E 000				
F 000		8.73, Emergency t ID# OJP311.	F 000				
	conducted from 11/2 the 15 complaint alleg substantiated.						
F 636 SS=D	Comprehensive Asse CFR(s): 483.20(b)(1)	-	F 636		12/19/19		
	a comprehensive, ac	luct initially and periodically					
	A facility must make a assessment of a resid goals, life history and resident assessment by CMS. The assess the following:	ent Assessment Instrument.					
	 (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavi (vii) Psychological week 	or patterns.					

Electronically Signed

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.

12/18/2019

		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 01/09/202 / APPROVE). 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345167	B. WING				C 21/2019
NAME OF PR	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1	
				903	3 W MAIN STREET		
	URSING CARE CENTER			YA	DKINVILLE, NC 27055		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 636	Continued From page	o 1		626			
F 030			F (636			
	()	s and health conditions.					
	(xi) Dental and nutriti	onal status.					
	(xii) Skin Conditions.						
	(xiii) Activity pursuit. (xiv) Medications.						
	(xv) Special treatmer	te and procedures					
	(xvi) Discharge plann	•					
		of summary information					
	. ,	nal assessment performed					
		gered by the completion of					
	the Minimum Data Se						
	(xviii) Documentation						
	. ,	sessment process must					
	include direct observation	ation and communication					
	with the resident, as	well as communication with					
	licensed and nonlicer						
	members on all shifts	S.					
		required. Subject to the d in §413.343(b) of this					
	-	st conduct a comprehensive					
		dent in accordance with the					
		in paragraphs (b)(2)(i)					
		ction. The timeframes					
		43(b) of this chapter do not					
	apply to CAHs.						
	.,	r days after admission,					
		ns in which there is no					
		the resident's physical or					
		r purposes of this section,					
		a return to the facility					
		/ absence for hospitalization					
	or therapeutic leave.) (iii)Not less than once						
	. ,	Γ is not met as evidenced					
	by:						
		ons, record review and staff			Resident number 2 has had an annua	al	
		/ failed to complete an			comprehensive assessment complete		
		/e MDS (minimum data set =			11/26/2019 with an ARD of 6/29/2019.		

Facility ID: 923574

If continuation sheet Page 2 of 21

				PRINTED: 01/09/203 FORM APPROVE OMB NO. 0938-039		
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED		
	345167	B. WING		C 11/21/2019		
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
JRSING CARE CENTER			903 W MAIN STREET YADKINVILLE, NC 27055			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE		
a tool used for residen within 366 days for 1 #2) reviewed. The findings included Resident #2 was adm 7/15/15 with diagnose alzheimers, hypertens depression. A quarterly MDS asse revealed Resident #2 cognition, required ex person for mobility an of bladder. A record m MDS completed 3/29, assessment prior to th annual comprehensiv An interview with MD2 10:48 AM revealed sh the facility in August of schedule was already started, so she just be they were working on assessments and car Qrtly Assessment at I CFR(s): 483.20(c) §483.20(c) Quarterly A facility must assess quarterly review instru and approved by CM3 once every 3 months. This REQUIREMENT by:	nt assessment) assessment of 23 residents (Resident : initted to the facility on es of, in part, ataxia, sion, hypothyroidism and essment dated 6/28/19 had moderately impaired the assistance of one ad was frequently incontinent eview revealed a quarterly /19 and a quarterly hat and was overdue for an re MDS assessment. S Nurse #2 on 11/21/19 at he started employment at of 2019. She stated the MDS r made out when she egan following it. She stated a system to get the e plans up to date. Least Every 3 Months Review Assessment a resident using the ument specified by the State S not less frequently than is not met as evidenced		All resident have the pote affected by the deficient p facility MDS department of 100% audit on all active m ensure no assessment has missed. This audit was of 12/13/2019. The regional clinical services provided the MDS Nurses on 12/18 addressing the types and assessment completion. The MDS department and review all residents MDS monthly to ensure that no have been missed. The regional Clinical will a census monthly times 3 m no missed assessments. The audits will be reviewed bi-weekly QA meeting and will be determined by the 38	Practice so the completed a esidents to ave been completed on I director of an in-service to 3/2019 time frames for d the DON will schedules assessments audit 20% of nonths to ensure ed at the d ongoing audits QA team. 12/19/19		
	S FOR MEDICARE & FOFICIENCIES CORRECTION OVIDER OR SUPPLIER JRSING CARE CENTER JRSING CARE CENTER INSING CARE CENTER CEACH DEFICIENC REGULATORY OR I Continued From page a tool used for reside within 366 days for 1 #2) reviewed. The findings included Resident #2 was adm 7/15/15 with diagnose alzheimers, hypertens depression. A quarterly MDS asse revealed Resident #2 cognition, required ex person for mobility an of bladder. A record r MDS completed 3/29 assessment prior to ti annual comprehensiv An interview with MD 10:48 AM revealed si the facility in August of schedule was already started, so she just be they were working on assessments and car Qrtly Assessment at I CFR(s): 483.20(c) §483.20(c) Quarterly A facility must assess quarterly review instru and approved by CM once every 3 months. This REQUIREMENT by:	CORRECTION IDENTIFICATION NUMBER: 345167 OVIDER OR SUPPLIER JESING CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 a tool used for resident assessment) assessment within 366 days for 1 of 23 residents (Resident #2) reviewed. The findings included: Resident #2 was admitted to the facility on 7/15/15 with diagnoses of, in part, ataxia, alzheimers, hypertension, hypothyroidism and depression. A quarterly MDS assessment dated 6/28/19 revealed Resident #2 had moderately impaired cognition, required extensive assistance of one person for mobility and was frequently incontinent of bladder. A record review revealed a quarterly MDS completed 3/29/19 and a quarterly assessment prior to that and was overdue for an annual comprehensive MDS assessment. An interview with MDS Nurse #2 on 11/21/19 at 10:48 AM revealed she started employment at the facility in August of 2019. She stated the MDS schedule was already made out when she started, so she just began following it. She stated they were working on a system to get the assessments and care plans up to date. Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A. BUILDIN B. WING_ OVIDER OR SUPPLIER 345167 B. WING_ DIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 2 a tool used for resident assessment) assessment within 366 days for 1 of 23 residents (Resident #2) reviewed. F 6 The findings included: Resident #2 was admitted to the facility on 7/15/15 with diagnoses of, in part, ataxia, alzheimers, hypertension, hypothyroidism and depression. A quarterly MDS assessment dated 6/28/19 revealed Resident #2 had moderately impaired cognition, required extensive assistance of one person for mobility and was frequently incontinent of bladder. A record review revealed a quarterly MDS completed 3/29/19 and a quarterly assessment prior to that and was overdue for an annual comprehensive MDS assessment. An interview with MDS Nurse #2 on 11/21/19 at 10:48 AM revealed she started employment at the facility in August of 2019. She stated the MDS schedule was already made out when she started, so she just began following it. She stated they were working on a system to get the assessment and care plans up to date. Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) F 6 §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by:	EPGR MEDICARE & MEDICAID SERVICES PEFFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA JUBNITIFICATION NUMBER: A. BUILDING JUBNITIFICATION NUMBER: STREET ADDRESS, CITY, STATE, ZIP VIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP JRSING CARE CENTER STREET ADDRESS, CITY, STATE, ZIP SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX Continued From page 2 All resident have the polt affected by the deficient plant a tool used for resident assessment) assessment within 366 days for 1 of 23 residents (Resident #2) reviewed. F 636 A quarterly MDS assessment dated 6/28/19 revealed Resident #2 had moderately impaired cognition, required extensive assistance of one person for mobility and was frequently inontinent of bladder. A record review revealed a quarterly MDS completed 3/29/19 and a quarterly massessment prior to that and was overdue for an annual comprehensive MDS assessment. The MDS department an review all residents MDS monthly to ensure that no have been missed. All neterive with MDS Nurse #2 on 11/21/19 at 10:48 AM revealed she started employment at the facility in August of 2019. She stated they were working on a system to get the assessment and care plans up to date. Orthy Assessment at Least Every 3 Months CF 638 F 638 F 638 F 638		

Facility ID: 923574

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM): 01/09/202 /I APPROVE). 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		LETED
		345167	B. WING			C 21/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
YADKIN N	URSING CARE CENTER	1		003 W MAIN STREET YADKINVILLE, NC 27055		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 638 F 641 SS=E	Set (MDS) assessme selected to be review Assessments. (Resid The Findings Include Resident #6 was adm 7/17/19. A review of (MDS) assessments last assessment complete MDS assessment complete MDS assessment complete MDS assessment on 11/24/19. An interview was con Coordinator on 11/20 interview, the MDS C missed completing th Resident #6. She sta should have been con after the admission at During an interview w on 11/21/19 at 2:12 P expectation that quar completed as require Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by:	Act a quarterly Minimum Data ent for 1 of 23 residents red for Resident ent #6). d: nitted to the facility on the Minimum Data Set for Resident #6 revealed the pleted was an admission ed on 7/24/19. No other ad been completed since ducted with the MDS /19 at 1:25 PM. During this oordinator stated she e quarterly assessment for ated it was an oversight and mpleted within three months ssessment. With the Director of Nursing PM, she stated it was her terly MDS assessments are d and scheduled. nents of Assessments. st accurately reflect the T is not met as evidenced	F 638	assessment completed on 11/22/2019 with an ARD of 10/18/2019. All resident have the potential to be affected by the deficient practice so th facility MDS department completed a 100% audit on all active residents to ensure no assessment have been missed. This audit was completed on 12/13/2019. The regional director of clinical services provided an in-service the MDS Nurses on 12/18/2019 addressing the types and time frames assessment completion. The MDS department and the DON wi review all residents MDS schedules monthly to ensure that no assessment have been missed. The regional Clinical will audit 20% of census monthly times 3 months to ens no missed assessments. The audits will be reviewed at the bi-weekly QA meeting and ongoing au will be determined by the QA team.	e to for ill is sure	12/19/19
	interviews, the facility	ns, record review and staff failed to accurately code et (MDS) assessment in the		Resident number 20 had their MDS modified on 12/16/2019 to show the accurate coding of section N of the MI	DS.	

Event ID: 0JP311

Facility ID: 923574

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		MEDICAID SERVICES				OMB NC	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		345167	B. WING				C 21/2019
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	1 11/	21/2019
0.002 01 1					3 W MAIN STREET		
YADKIN N	IURSING CARE CENTER				ADKINVILLE, NC 27055		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 641	Continued From page	<i>م</i>	F 64	11			
1 011	areas of medications		F 04	+ 1	This modification has been transmitted	to	
		105, 109 and 106) residents			the state on 12/16/2019.	10	
		nal status for 1 of 1 residents			Resident number 73 had their MDS		
	(Resident #64) review	wed for nutrition.			modified on 12/16/2019 to show the		
					accurate coding of section N of the MD	DS.	
	The findings included	1:			This modification has been transmitted	to	
					the state on 12/16/2019.		
	3/7/16 with a diagnos	admitted to the facility on			Resident number 105 had their MDS		
	3/7/10 with a diagnos	is of hypertension.			modified on 12/16/19 to show the		
	A quarterly MDS asse	essment dated 8/23/19			accurate coding of section N of the ME	DS.	
		0 had an active diagnosis of			This modification has been transmitted		
		DS did not refect Resident			the state on 12/16/19.		
	#20 had received a d				Resident number 106 had their MDS		
	assessment look bac	k period.			modified on 12/16/19 to show the	NC	
	A record review revea	aled a physician ' s order			accurate coding of section N of the MD This modification has been transmitted		
		ix 20 milligrams daily.			the state on $12/16/19$.	10	
		nistration Record (MAR) for			Resident number 64 had their MDS		
	August 2019 revealed	d Resident #20 had received			modified on 12/16/19 to show the		
	Lasix 20 milligrams 7	-			accurate coding of section G of the ME		
	assessment look bac	k period.			This modification was transmitted to the	е	
	An intensious with MD	S Nurse #2 on 11/21/19 at			state on 12/16/19. Resident number 109 had their MDS		
		he completed the medication			modified on 12/16/19 to show the		
		y looking at the physician			accurate coding of section N of the MD	DS.	
		he must have missed the			This modification was transmitted to the		
	diuretic for Resident #	# 20.			state on 12/16/19.		
	2. Resident #73 was	admitted to the facility on			All resident have the potential to be		
	-	es included, in part, atrial			affected by the deficient practice so the	e	
	fibrillation and anxiety	/.			facility MDS department completed a		
		esement dated 10/11/10			100% audit on all active residents mos recent MDS to ensure that sections G		
		essment dated 10/11/19 '3 had active diagnoses of			N of the MDS were accurate. This auc		
		illation. The MDS did not			was completed on 12/16/19. The region		
	reflect Resident #73 h				director of clinical services provided an		
	anticoagulant medica				in-service to the MDS Nurses on		
	medication.				12/18/2019 addressing accurate coding	aof	

Facility ID: 923574

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		MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. (X3) DATE S	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPL	
					с	
		345167	B. WING		11/2	1/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
YADKIN N	URSING CARE CENTER	ł		903 W MAIN STREET YADKINVILLE, NC 27055		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From page 5		F 64	11		
	Continued From page 5 A record review revealed a physician 's order for buspar 22.5 milligrams by mouth twice a day ordered on 3/25/19 and a physician 's order for Eliquis 2.5 milligrams by mouth twice a day ordered 11/2/16. Resident #73 's MAR for October 2019 indicated she had received buspar 22.5 milligrams twice a day and Eliquis 2.5 milligrams twice a day each day during the look back period. An interview with MDS Nurse #2 on 11/21/19 at 10:48 AM revealed she completed the medication section of the MDS by looking at the physician orders. She stated she did not catch that Resident #73 was taking an anticoagulant or an antianxiety medication. 3. Resident # 105 was admitted to the facility on 1/29/18 with diagnoses that included, in part, lewy body dementia and Parkinson 's disease. A review of the physician 's orders revealed Celexa 20 milligrams daily for lewy body dementia. Resident #105 was not prescribed an			sections G and N of the M The Regional Director of will conduct an audit of 20 completed weekly to ensu coding of Sections N and Results of the audits will I the Monthly QA meeting a will be at the direction of t	Clinical Services D% of MDS ure accurate G. be reviewed at and further audits	
	#105 had active diag MDS did not indicate	d 11/1/19 revealed Resident noses of dementia. The Resident was taking an ad, Resident #105 ' s MDS				
	2019 indicated Resid	for October and November ent #73 received celexa 20 out of 7 days of the look				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345167	B. WING				C / 21/2019
NAME OF P	ROVIDER OR SUPPLIER	I		ę	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
YADKIN N	URSING CARE CENTER			903 W MAIN STREET YADKINVILLE, NC 27055			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 641		S Nurse #2 on 11/21/19 at ne must have coded the	F	641			
	10/25/19 with diagnost cerebrovascular disea cerebral infarction.	s admitted to the facility on ses that included, in part, ase and dysphagia following Medication Administration					
		ted Resident #106 was not ulant medication nor had he gulant medication.					
	revealed Resident #1	ation four of seven days					
	she coded medication they were coded per how they were used. received Brilinta, 90 r MDS Nurse #1 stated	AM an interview was Nurse #1. She said when ns on section N of the MDS drug classification and not She indicated the resident nilligrams, twice a day. I she coded the medication but when she researched					
	the classification of the interview she discover medication. She ack coded a zero under the 5. Resident #64 was 7/28/15 with diagnose profound intellectual	ne medication during the ered it was an anti-platelet nowledged she should have ne anti-coagulant section. admitted to the facility on es that included, in part,					

Facility ID: 923574

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/09/2020 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY LETED
		345167	B. WING				C 21/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
YADKIN N	URSING CARE CENTER			903 W MAIN STREET YADKINVILLE, NC 270	55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page (PVD).	97	F 64	41			
	 #64 had severe cogni one-to-two-person tot of daily living (ADLs), bladder and bowel. T 9/20/19 documented to two-person extensive mobility, locomotion of personal hygiene. During an interview wi 10:30 AM she stated total assistance by on all ADLs and a mecha Resident #64 from his stated that this assista 9/20/19. During an observation the resident was transito to his bed using a me members to perform i During an interview wi 11/20/19 at 1:35 PM to based on what the nut documented. If the N assistance, then extend documented in the Mile education needed to be could correctly identify versus total assistance 	/4/19 indicated Resident tive deficit, required al assistance with activities and was incontinent of the previous MDS dated for that the resident required assistance with bed on the unit, toilet use, and ith Nurse #2 on 11/20/19 at that the resident requires that the resident requires that the resident requires be to two staff members for anical lift is used to transfer ab bed to his wheelchair. She ance was required prior to an on 11/20/19 at 11:10 AM sferred from his wheelchair chanical lift by three staff ncontinence care. ith MDS #1 and MDS #2 on hey stated that they code rse assistants (NAs) As documented extensive nsive assistance would be DS. They stated that be given to the NAs so they y extensive assistance					
	on 11/21/19 at 2:15 P	Ith the Director of Nursing M, she stated that Resident I assistance with all ADLs					

Facility ID: 923574

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345167	B. WING				C / 21/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
YADKIN N	IURSING CARE CENTER				903 W MAIN STREET YADKINVILLE, NC 27055		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY) DEFICIENCY)					(X5) COMPLETION DATE	
F 641	for a long time and th 6. Resident #109 wa 11/20/2013 with diagr disease, dementia, hy depressive disorder, a A review of the admis revealed Resident #1 following classes of m days either prior or du assessment: antipsyc hypnotic, anticoagula and opioid. A review of the physic 2019 revealed Resided dated 4/29/19 for Risp milligrams (mg) by mo medication orders fro classes noted on the were found. A review of the Medic for September 2019 r received only Risperce but was not receiving hypnotic, anticoagula or opioid medications MDS assessment. An interview with the 11/21/19 at 10:47 AM quarterly MDS assess not accurate. The MD Resident #109's 9/13, antipsychotic medication other medication class	e MDS should reflect that. s admitted to the facility on noses including: Parkinson's /pokalemia, major and kidney failure. sion MDS dated 9/13/19 09 was actively taking the nedications for at least 7 uring his last MDS shotic, antidepressant, nt, antidepressant, diuretic, cian's orders for September ent #109 had an active order berdal (an antipsychotic) 0.5 both twice daily. No other m the above medication resident's 9/13/19 MDS ration Administration Record evealed Resident #109 lal 0.5 mg (an antipsychotic), any antidepressant, nt, antidepressant, diuretic, as specified on the 9/13/19 MDS nurses #1 and #2 on revealed Resident #109's sment dated 09/13/19 was 0S nurses specified on /19 MDS assessment tions should have been the with 7 days denoted-all	F	64			

Facility ID: 923574

If continuation sheet Page 9 of 21

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 01/09/2020 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345167	B. WING			_		C 21/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				90	03 W MAIN STREET			
YADKIN N	URSING CARE CENTER			Y.	ADKINVILLE, NC 2705	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)	omprehensive Care Plan	F	656				12/19/19
	care plan for each response resident rights set fort §483.10(c)(3), that incomplete the set of the	illity must develop and ensive person-centered ident, consistent with the h at §483.10(c)(2) and cludes measurable mes to meet a resident's mental and psychosocial ed in the comprehensive aprehensive care plan must - re to be furnished to attain nt's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ing the right to refuse .10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its nt's medical record. In the resident and the ive(s)- als for admission and ference and potential for lities must document a desire to return to the seed and any referrals to a and/or other appropriate						

Facility ID: 923574

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION	(X3) DA	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COI			
		345167	B. WING		1	C 1/21/2019		
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CC				
	URSING CARE CENTER			903 W MAIN STREET				
	UNUNG DARE DENTER			YADKINVILLE, NC 27055				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE		
F 656	Continued From page	e 10	F 65	6				
		in accordance with the	1 00					
		h in paragraph (c) of this						
	section.							
		「 is not met as evidenced						
	by: Based on observatio	n, staff interviews and		Resident number 27 had th	eir			
		cility failed to develop a care		comprehensive care plan up				
	plan that addressed t	he use of oxygen for 1 of 5		reflect the use of Oxygen on	11/22/2019.			
		27) reviewed for oxygen		Resident #64 had their care				
		develop a care plan that e ulcer for 1 of 3 residents		to reflect current Pressure u 11/25/2019.	icer on			
		ved for pressure ulcers.		All Residents have the poter	ntial to be			
		·		affected if their Comprehens				
	Findings included:			are not current and reflective				
	1 Desident #27 was	admitted to the facility on		status so the Director of Clir				
		admitted to the facility on the hospital on 11/8/19		provided the MDS Departme in-service on 12/18/2019 reg				
		e facility on 11/14/19 with		Comprehensive care plans.	Jarang			
		led, in part, pneumonia,		The MDS Department and the				
	hypoxemia and dyspi	nea.		completed a 100% audit of a				
	A physician order dat	ed 11/14/19 stated, "Oxygen		residents care plans on 12/1 ensure all pressure ulcers a				
		face mask at 2-5 liters per		use is care planned.	nd oxygen			
	minute continuously f			The Regional Director of Cli				
	distress/shortness of	breath."		will completed a weekly aud				
	The quarterly Minimu	um Data Set (MDS)		completed Comprehensive of one month.	care plans for			
		6/19 indicated Resident #27		The results of the audit will t	pe reviewed at			
		t. He had shortness of		the Monthly QA meeting and				
		athing when lying flat and		will be at the discretion of th	e QA Team.			
	received oxygen ther	ару.						
	The care plan, update	ed 9/11/19, had not						
	addressed the use of							
	An observation of Re	sident #27 was made on						
		1. The resident was lying in						
	bed with oxygen on a	it 3.5 liters via nasal cannula.	1					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/09/2020 APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345167	B. WING		_		C 21/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
YADKIN N	URSING CARE CENTER			003 W MAIN STREET ADKINVILLE, NC 2705	55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	aspiration pneumonia plan for Resident #27 on continuous oxyger included in the care p An interview with MD2 10:35 AM revealed th have been on Reside reported both she and at the facility less than "catch up the care pla working at the facility. they used the 24 hour they updated care pla During an interview w (DON) on 11/21/19 at the care plan was sup what was going on wi the use of oxygen sho plan. The DON said I the MDS position and MDS training seminar 2. Resident #64 was a 7/28/15 with diagnose profound intellectual of hypothyroidism, and p (PVD). A physician's order w apply Silver Sulfadiaz sacrum/coccyx every order was placed on f	AM an interview was Nurse #2. She stated oxygen due to a history of . She completed the care and explained since he was it should have been lan. S Nurse #1 on 11/20/19 at e use of oxygen should int #27's care plan. She d MDS Nurse #2 had been in nine months and had to ins" when they first started MDS Nurse #1 explained report information when ins. ith the Director of Nursing 11:09 AM she expressed oposed to be a snapshot of th the resident and thought ould be included in the care MDS Nurse #2 was new to was scheduled to attend a in the next few weeks. admitted to the facility on es that included, in part, disabilities, aphasia, beripheral vascular disease	F 656				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
345167		B. WING				C 21/2019	
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
YADKIN NURSING CARE CENTER					903 W MAIN STREET YADKINVILLE, NC 27055		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	The quarterly Minimul assessment dated 10 #64 had severe cogni extensive to total assi- living, and was incont In Section M, Resider have a stage 2 press present on admission The Care Plan dated in place for the potent related to incontinence non-ambulatory, PVD contractures of hands added to address the and/or stage 2 press On 11/20/19 at 1:31 F completed with MDS stated that they were that addressed press addition to the potenti plan. During an interview w on 11/21/19 at 2:12 P expected that care pla with the resident. She had a pressure ulcer,	m Data Set (MDS) /4/19 indicated Resident tive deficit, required stance with activities of daily inent of bladder and bowel. In #64 was documented to ure ulcer that was not for 10/13/17 revealed a plan tial for skin impairment e of bowel/bladder, n, and has bilateral actual skin impairment ure ulcer.	F	656			
F 657 SS=D	address it. Care Plan Timing and CFR(s): 483.21(b)(2)(F	657	,		12/19/19
	be-	ensive Care Plans orehensive care plan must days after completion of					

Facility ID: 923574

If continuation sheet Page 13 of 21

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/09/20 FORM APPROVE OMB NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345167	B. WING		C 11/21/2019
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
YADKIN NURSING CARE CENTER				03 W MAIN STREET	
			Y	ADKINVILLE, NC 27055	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 657	Continued From pag	e 13	F 657		
	the comprehensive a		1 007		
	· ·	terdisciplinary team, that			
	includes but is not lin				
	(A) The attending ph				
	(B) A registered nurs	e with responsibility for the			
	resident.				
		responsibility for the			
	resident.	d and nutrition services staff.			
		cticable, the participation of			
		resident's representative(s).			
		be included in a resident's			
		participation of the resident			
	and their resident rep	presentative is determined			
	not practicable for the	e development of the			
	resident's care plan.				
		e staff or professionals in			
		nined by the resident's needs			
	or as requested by th	vised by the interdisciplinary			
		essment, including both the			
	comprehensive and				
	assessments.	. ,			
	This REQUIREMEN	Γ is not met as evidenced			
	by:				
		ons, record review and staff		Resident number 105 had their car	
	-	/ failed to update the care		updated on 11/25/2019 to reflect ac	curate
		ht loss for 1 of 4 (Resident trition and continence status		assistance for adl□s. Resident number 64 had their care	nlan
		Resident #105 and Resident		updated on 11/25/2019 to reflect	high
	#2) reviewed for activ			accurate interventions on the Nutriti	ion
	,	· · · ·		care plan to include discontinue of	
	The findings included	d:		weights.	
	1 Desident #64 was	admitted to the facility on		All residents have the potential to be	
		admitted to the facility on es that included, in part,		affected by the deficient practice so MDS department and DON complete	
	profound intellectual			100% audit of all resident s nutrition	
	-	peripheral vascular disease		interventions and adl assistance to	
	(PVD).			it was care planned as appropriately	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345167		B. WING			C 11/21/2019			
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
YADKIN NURSING CARE CENTER								
				Ť	ADKINVILLE, NC 27055			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
TAG F 657	Continued From page The quarterly Minimu assessment dated 10 #64 had severe cogni one-to-two-person tot of daily living (ADLs), bladder and bowel. T 9/20/19 documented two-person extensive mobility, locomotion of personal hygiene. Th the MDS and no weig On 05/02/2019, the resid which is a -3.74 % Lo weight was on 7/02/2 weights were listed. Review of Physician of discontinue monthly v palliative goals. Review of a Dietary N Resident #64 had a s needed increased por increase protein intak 75-100%. He receive and had between mea Resident #64 remaine with no feeding tube a discontinued as order	e 14 m Data Set (MDS) /4/19 indicated Resident titve deficit, required al assistance with activities and was incontinent of The previous MDS dated for that the resident required assistance with bed on the unit, toilet use, and here was no weight listed on the unit, toilet use, and here was no weight listed on the loss noted. esident weighed 107 lbs. On ent weighed 103 pounds ss. The last documented 019 at 100lbs. No other orders revealed an order to veights on 7/10/19 due to lote from 10/3/19 stated that tage 2 pressure ulcer, rtions of eggs at breakfast to e, breakfast intake is ed supplements with meals al snacks three times a day. ed on comfort measures and monthly weights were red.		657		ices ices are ed at		
	#64 was at risk for alt need for assist with m disability and impaired extremities. The care	• 4/8/19 stated that Resident ered nutrition related to neals due to intellectual d dexterity to bilateral upper e plan did not address actual ventions in place. One of the						

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/09/2020 MAPPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938- (X3) DATE SURVEY COMPLETED		
		345167	B. WING		_		C 21/2019
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			9	03 W MAIN STREET			
YADKIN N	URSING CARE CENTER		Y	ADKINVILLE, NC 2705	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	 plan was to obtain were During an interview were 1:20 PM she stated the should have been upon utritional status and discontinued. During an interview were During an interview were nutritional status and discontinued. During an interview were and the states and the states of the scale of the	nted on Resident #64's care ights. ith MDS #1 on 11/20/19 at hat the resident's care plan dated to reflect his current that his weights were ith the Director of Nursing M, she stated that Resident d have been updated to ritional interventions. She ht was no longer getting his to comfort care. admitted to the facility on es of, in part, lewy body son ' s disease. imum Data Set (MDS) /1/19 revealed Resident ive assistance of 2 people always incontinent of 6/18 indicated Resident ncontinent of bladder related status. The goal was for ain continent during the ays. Interventions included, re after each incontinent ge fluids while awake. /20/19 at 12:42 PM revealed room sitting in a wheelchair.	F 657		DEFICIENCY)		
	make her needs knov	ame only and was unable to /n. An interview in bservation with Nursing					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345167		B. WING				C 21/2019		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
					903 W MAIN STREET			
YADKIN N	URSING CARE CENTER		YADKINVILLE, NC 27055					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	Y FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE	
F 657	Assistant #2 revealed incontinent of bowel a unable to let staff kno bathroom. An interview on 11/21 Nurse #2 revealed sh facility since August. I Resident #105 ' s car updated when the cor was done. She stated and that the care plan they were still trying to to keep the care plans 3. Resident #2 was au 7/15/15 with diagnose Alzheimer ' s. The last MDS assess quarterly done on 6/2 #2 was always incont A care plan dated 1/1 episodes of urinary in decreased mobility, w An interview with Nur 11/20/19 at 10:12 A re total care. She stated her and she was alway bladder. She stated F the staff know she ha An interview on 11/2	Resident #105 was always and bladder and she was w when she had to use the /19 at 10:48 with MDS e had been working at the MDS Nurse #2 stated e plan should have been mprehensive assessment I was new to the position as were a work in progress, o determine the best system s up to date. dmitted to the facility on es of, in part, ataxia and ment completed was a 8/19 that indicated Resident inent of bowel and bladder. 3/17 indicated a problem of continence related to yeakness and Alzheimer ' s. sing Assistant #1 on evealed Resident #2 was the staff did everything for ays incontinent of bowel and Resident #2 was unable to let d to use the bathroom. 1/19 at 10:48 with MDS	F	657				
	facility since August. I Resident #105 ' s car	e had been working at the MDS Nurse #2 stated e plan should have been mprehensive assessment						

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		MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345167		. ,		(X3) DATE SURVEY COMPLETED	
		B. WING		C 11/21/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1==0.0
YADKIN NURSING CARE CENTER				903 W MAIN STREET YADKINVILLE, NC 27055	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 657	and that the care plar	l was new to the position is were a work in progress, o determine the best system	F 657	7	
F 867 SS=E	QAPI/QAA Improvem CFR(s): 483.75(g)(2)	ent Activities	F 867	7	12/19/19
	§483.75(g) Quality as	sessment 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 by: Based on observations, record review and staff interviews, the facilities Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor their interventions that the committee put into place following the recertification and complaint survey conducted on 12/6/18. This was for three deficiencies that were originally cited in the area of Comprehensive Assessments and Timing (F636), Quarterly Minimum Data Set (MDS) Assessments at least every three months (F638 and Accuracy of MDS Assessments (F641) in December 2018 and recited on the current recertification and complaint investigation survey of 11/21/19. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. 			The original Plan of Correction from 12/6/2018 will be reviewed by the QA. Committee and updated as necessary The Plan of Correction will be implemented upon completion of the review. The QAA Committee will complete the review of the 12/6/2018 Plan of Corre to identify any past deficiencies and ensure compliance going forward. The Administrator or designated representative will review the Plan of Correction from 12/6/2018 to ensure a measures and recommendations are being followed. This review will contin weekly for 4 weeks then monthly for 6 months.	y. e ction all ue
	Findings included: This tag is cross refer	renced to:		The Administrator or designated representative will report findings of the	ne

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TATEMENT	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
345167 B NAME OF PROVIDER OR SUPPLIER B					С	
		B. WING		1	1/21/2019	
			STREET ADDRESS, CITY, STATE, ZIP COD	E		
YADKIN NURSING CARE CENTER				903 W MAIN STREET YADKINVILLE, NC 27055		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 867	Timing- Based on obs and staff interviews, t an annual comprehen- set; a tool used for re- assessment within 36 reviewed. (Resident # During the facility's re- investigation survey of to complete an annual assessment within 36 (Resident # 9) review assessments. An interview was com- on 11/21/19 at 10:32 unaware of the misse further revealed that s felt like she had not re- yet regarding MDS co An interview conducte Nursing (DON) on 11/ the facility did have an and Assurance Comm every other Wednesd committee was currer evacuations and eme the committee meetin on care than MDS ch 2. F638- Based on	ensive Assessments and servations, record review he facility failed to complete nsive MDS (minimum data sident assessment) 66 days for 1 of 23 residents 42) certification and complaint on 12/06/18, the facility failed al comprehensive 66 days for 1 of 28 residents ed for comprehensive ducted with the MDS nurse AM who stated she was d MDS assessments. She she was new to the role and eceived appropriate training ompletion. ed with the Director of /21/19 at 11:08 AM revealed in active Quality Assessment nittee and they met usually ay. The DON revealed the ntly working on mock rgency preparedness and togs had been focused more arting.	F 86	Committee to determine if the put in place are adequate or i updates are necessary. The <i>A</i> or designated representative finding once a month for 6 mo necessary, the QAA Committe extend reports until substantia compliance is achieved.	f any Administrator will report onths. If ee will	
	interviews, the facility Minimum Data Set (N	failed to conduct a quarterly IDS) assessment for 1 of 23 be reviewed for Resident				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED C NAME OF PROVIDER OR SUPPLIER 345167 B. WING 11/21/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11/21/20 YADKIN NURSING CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 903 W MAIN STREET YADKINVILLE, NC 27055 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COM		RTMENT OF HEALTH AN ERS FOR MEDICARE &					FORM	0: 01/09/2020 APPROVED 0. 0938-0391
345167 B. WING 11/21/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 903 W MAIN STREET YADKIN NURSING CARE CENTER 903 W MAIN STREET YADKINVILLE, NC 27055 (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) COM COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 867 Continued From page 19 investigation survey on 12/06/18, the facility failed to conduct quarterly Minimum Data Set (MDS) assessments for 4 of 28 residents reviewed for F 867	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE YADKIN NURSING CARE CENTER 903 W MAIN STREET YADKINVILLE, NC 27055 YADKINVILLE, NC 27055 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX F 867 Continued From page 19 F 867 investigation survey on 12/06/18, the facility failed to conduct quarterly Minimum Data Set (MDS) assessments for 4 of 28 residents reviewed for F 867	345167			B. WING		_		
YADKIN NURSING CARE CENTER YADKIN NURSING CARE CENTER YADKINVILLE, NC 27055 (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) COM F 867 Continued From page 19 investigation survey on 12/06/18, the facility failed to conduct quarterly Minimum Data Set (MDS) assessments for 4 of 28 residents reviewed for F 867	NAME OF PRO	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM COM COM CONSTRUCTION F 867 Continued From page 19 investigation survey on 12/06/18, the facility failed to conduct quarterly Minimum Data Set (MDS) assessments for 4 of 28 residents reviewed for F 867	YADKIN NURSING CARE CENTER					55		
investigation survey on 12/06/18, the facility failed to conduct quarterly Minimum Data Set (MDS) assessments for 4 of 28 residents reviewed for	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA		(X5) COMPLETION DATE
 19). An interview was conducted with the MDS nurse on 11/21/19 at 10:32 AM who stated she was unaware of the missed MDS assessments. She further revealed that she was new to the role and felt like she had not received appropriate training yet regarding MDS completion. An interview conducted with the Director of Nursing (DON) on 11/21/19 at 11:08 AM revealed the facility did have an active Quality Assessment and Assurance Committee and they met usually every other Wednesday. The DON revealed the committee was currently working on mock evacuations and emergency preparedness and the committee meetings had been focused more on care than MDS charting. 3. F641- Based on observations, record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of medications received for 5 of 23 (Resident # 's 20, 73, 105, 1 and 106) residents reviewed and functional status for 1 of 1 residents reviewed and functional status for 1 of 1 residents reviewed and functional status for 1 of 1 resident receiving a medication and complaint investigation survey on 12/06/18, the facility was cited at F-641 for failing to accurately code the Minimum Data Set (MDS) assessment for a resident receiving a medication for 1 of 1 (Resident #18) residents reviewed for Unnecessary Medications. 	i t t a F F C C C C C C C C C C C C C C C C C	 investigation survey of to conduct quarterly M assessments for 4 of Resident Assessment 19). An interview was con on 11/21/19 at 10:32 unaware of the misse further revealed that s felt like she had not re yet regarding MDS con An interview conducted Nursing (DON) on 11, the facility did have a and Assurance Commevery other Wednesd committee was current evacuations and ement the committee meeting on care than MDS ch F641- Based on and staff interviews, the accurately code the M assessment in the area for 5 of 23 (Resident # During the facility's re- investigation survey of cited at F-641 for failii Minimum Data Set (M resident receiving a m (Resident #18) reside 	on 12/06/18, the facility failed Minimum Data Set (MDS) 28 residents reviewed for ts. (Resident # 5, 3, 24, and ducted with the MDS nurse AM who stated she was ed MDS assessments. She she was new to the role and eceived appropriate training ompletion. ed with the Director of /21/19 at 11:08 AM revealed n active Quality Assessment nittee and they met usually lay. The DON revealed the ntly working on mock ergency preparedness and ngs had been focused more arting. tobservations, record review the facility failed to Minimum Data Set (MDS) eas of medications received # ' s 20, 73, 105, 1 and 106) nd functional status for 1 of 1 e64) reviewed for nutrition. ecertification and complaint on 12/06/18, the facility was ng to accurately code the MDS) assessment for a nedication for 1 of 1 ents reviewed for	F 867				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/09/2020 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		345167	B. WING					C 21/2019
NAME OF P	ROVIDER OR SUPPLIER	I	I	S	STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
	IURSING CARE CENTER				03 W MAIN STREET ADKINVILLE, NC 27055			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF 0 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD B		(X5) COMPLETION DATE
F 867	An interview was con on 11/21/19 at 10:32 unaware of the MDS inaccurate. She furth new to the role and fe appropriate training y completion. An interview conducte Nursing (DON) on 11, the facility did have a and Assurance Comm every other Wednesd committee was current evacuations and eme	ducted with the MDS nurse AM who stated she was assessments were er revealed that she was at like she had not received et regarding MDS ed with the Director of /21/19 at 11:08 AM revealed n active Quality Assessment nittee and they met usually lay. The DON revealed the ntly working on mock ergency preparedness and hgs had been focused more	F	867				

Facility ID: 923574

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