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 02/05/2021

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

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E 000	Initial Comments An unannounced Recertification survey was conducted on 2/02/2021 through 02/05/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # N21B11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 2/2/2021 - 2/5/2021. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID # N21B11 3 of 15 complaint allegations were substantied.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		3/1/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/01/2021

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

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F 580	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff, Responsible party, physician and registered dietician (RD) interviews, the facility failed to notify the physician, RD and the Responsible party of a Resident's significant weight loss equaling 6% of body weight in two weeks and 11% of body	F 580	1.On 8/19/2020 the physician was notified of resident #2 change of condition which was after discharge. Resident #2 discharged from the facility on 8/7/2020 so further notification and intervention is not possible.	

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F 580	Continued From page 2 weight in 30 days for 1 of 2 residents reviewed for nutrition (Resident #2). The Findings included: Resident #2 was admitted to the facility on 6/29/2020 with diagnosis including anemia, vascular dementia, depression, chronic wound to the ankle and lipoprotein metabolism and was discharged on 8/7/2020. The Physician (MD) progress notes revealed the MD had assessed Resident #2 on 6/30/2020. The MD documented the Resident had a rapid decline in health over the past year and ordered Pro Stat (liquid protein nutritional supplement), 30 ml three times a day, based on a recent decrease in food intake. He added to monitor the resident for changes related to diuretic and hypertensive therapy combined with poor intake. Review of Resident #2's medical orders revealed Prostat 30 ml, three times a day was ordered on 6/30/2020 by the facility medical director. Resident #2's admission Minimum Data Set (MDS) assessment dated 6/29/2020, revealed the Resident's admission diagnosis included Anemia, diuretic therapy, Vascular dementia, depression, Chronic ulcer/wound to the ankle and disorders of lipoprotein metabolism. The Resident was coded to be moderately cognitively impaired, require one-person limited assistance with eating and had an admission weight of 168.9 pounds (lbs.). The care area assessment (CAA) summary dated, 7/6/2020, indicated Resident #2 was at risk for a nutritional deficit and indicated the resident would be care planned for at risk for a nutritional deficit.	F 580	2.On February 25, 2021 Director of Nursing identified residents with significant weight loss (>5% in 30 days or >10% in 180 days)for the month of February 2021. Food Service Director to assure physician, responsible party and Registered Dietician are notified of all significant weight losses by 3/1/2021. 3.The Food Service Director along with the Weight Committee will review for additional significant weight losses weekly to assure physician, responsible parties and Registered Dietician are notified of any residents found to have significant weight losses. Licensed nurses and Food Service Director were re-educated 2/23/2021 through 2/26/21 by the Director of Nursing on notification to physician and responsible parties with any change in condition. Any nursing staff member not in attendance will not be allowed to work until education completed. 4.The Director of Nursing or designee will initiate QA audit on 3/1/2021 all residents with significant weight loss 1 x weekly x 3 months to assure physician and Registered Dietician have been notified. The Director of Nursing or designee will report findings to QA Committee monthly x 3 months and on-going as needed and deemed by QA Committee. The Administrator will be responsible for implementing the acceptable plan of correction.	

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F 580	Continued From page 3	F 580		

Review of Resident #2's plan of care, dated 7/6/2020, included a focus area for being at risk for dehydration r/t diuretic therapy with interventions that included to monitor for interactions/adverse consequences and monitor for possible side effects every shift. A focus area for antidepressant medication with increased risk for adverse side effects of depression was documented. The interventions included to observe and report to the MD as needed ongoing signs and symptoms of depression unaltered by antidepressant meds and report to the nurse the following, decreased appetite, confusion, mood change, change in normal behavior, decline in ability to help with Activities of daily living. The care plan did not include a focus area for at risk for altered nutritional status.

Review of the assessments revealed the Registered Dietitian (RD) assessed Resident #2 on 7/1/2020 and included a progress note that stated Resident #2 had poor food intake. The RD recommended the Resident maintain a weight of 175 lbs. and to continue to monitor and add to the plan of care. The RD documented the resident weight as 184 lbs.

Review of the weights in the electronic medical record for Resident #2 documented a weight on admission, 6/30/2020, of 168.9 pounds (lbs.), on 7/1/2020 of 184.0 lbs. and on 7/30/2020 of 150.1 lbs.

A review of documentation provided by the restorative nursing program and stored in an office filing cabinet revealed additional weight results for the Resident on 7/16/2020 of 158.4 lbs., on 7/21/2020 of 158.1 lbs. and on 7/28/2020

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F 580	Continued From page 4	F 580		

of 150.1 lbs.

An interview was conducted on 2/3/2021 at 10:35 a.m. with the MDS nurse and she revealed that the facility process was to complete weekly weights 4 weeks, on all new admissions. She stated the weekly weights should be entered in a resident's chart on Wednesday of each week, after the weekly weights committee meeting. She stated the restorative aid was responsible for conducting weekly weights and reported them to the weights committee for review. She stated the nurse over the restorative program was responsible for ensuring the weights had been completed, as ordered. The MDS nurse added that she was the nurse responsible for the restorative program in June and July 2020.

An interview was conducted on 2/3/2021 at 11:18 a.m. with the restorative nursing assistant. She stated Resident #2 had weekly weights during the facility stay. She provided documentation of weekly weights and stated the weights had been provided to the weekly weights committee on Wednesday of each week. She revealed the committee would then document the weight in the medical record and notify the family, MD and RD as indicated from the results. She stated Resident #2 was recommended to continue weekly weights after the 7/28/2020 weight of 150.1 lbs.

An interview was conducted with the Director of Nursing (DON) on 2/3/2021 at 11:45 a.m. and she stated a note book with documentation of the weights committee meetings was maintained with orders and interventions during June and July of 2020. The DON stated the committee reviewed Resident #2 for the initial weight loss, dated

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F 580	Continued From page 5	F 580		

7/16/2020, and determined the 5% loss could be from diuretic therapy in the facility and intravenous therapy at the hospital, prior to admission. An intervention to continue to monitor was recommended by the team. The DON added that Resident #2 was discussed on the date of her discharge, 8/7/2020, and that interventions for weight loss had been recommended, that included, supplements with the meal tray, weekly weights and an RD evaluation.

A telephonic interview was conducted with the RD, on 2/5/2021 at 11:47 a.m. She stated that the COVID-19 pandemic prevented in person visits and that she relied on accurate documentation of a weight to carry out an assessment. She stated the only weight available for the assessment of Resident #2, on 7/1/2020, was a weight of 184 in the electronic system titled, PCC, and the weight had been documented by the facility dietary manager from the Hospital discharge summary and facility admission paperwork. She stated the admission weight of 168.9, on 6/30/2020 was documented in PCC after her assessment, as a late entry. She revealed the facility process was for the weights committee to send an email to notify the RD of wounds and significant weight loss. She denied receiving notification of the inaccuracy of the weight, dated 7/1/2020, and denied receiving notification of weight loss during the month of July 2020 for Resident #2. The RD added that it was her expectation to receive notification for significant weight loss and that included anything greater than 5%.

A telephonic interview was conducted with the MD, on 2/5/2021 at 1:48 p.m. and he stated that he had seen Resident #2 on 6/30/2020 and again on 8/7/2020. He denied receiving any notification

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F 580	Continued From page 6 of significant weight loss prior to the Resident's discharge on 08/07/20. He stated it was his expectation that any weight loss of greater than 5% in one month be reported to the MD for evaluation. He stated he was utilizing PCC documentation in July of 2020 and relied on accurate and timely documentation during visits. He denied having access to, or knowledge of, the weights documented by the restorative nursing assistant in July 2020. He stated he expected the facility to be aware of the federal regulations regarding the definition of significant weight loss, would educate the facility of his expectation for notifications and that he required a list of all areas that documentation was to be stored if not in the PCC system. A review of the medical record for Resident #2 revealed an MD notification for weight loss for Resident #2 initialed by the MD of receipt on 8/21/2020. Resident #2 was discharged to the Emergency room, for evaluation, on 8/7/2020 and did not return to the facility. A telephonic interview was conducted with the responsible party (RP) for Resident #2 on 2/2/2021 at 2:04 p.m. The RP denied receiving any information regarding weight loss of the resident. She stated therapy staff would notify her that the resident had not been eating much.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		3/1/21

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F 641	Continued From page 7 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of diagnoses for 1 of 2 residents (Resident #1) reviewed. The findings included: Resident #1 was admitted to the facility on 5/8/20 with diagnosis of left hip fracture. A nurse ' s note dated 7/15/20 at 3:43 PM read, "resident complaining of congestion and cough, bilateral lungs have scattered crackles, oxygen saturation level 97 percent on room air. Spoke with physician regarding ordering chest xray. Xray order obtained and called in". Results of the ordered chest xray ordered 7/15/20 revealed "mild pulmonary infiltrate in the left lung base and small left pleural effusion was present consistent with congestive heart failure (CHF) versus pneumonia". A physician ' s progress note dated 7/16/20 revealed a new diagnosis of CHF. A review of the quarterly MDS assessment dated 8/15/20 revealed CHF was not coded under Section I, Active Diagnoses. An interview with the MDS nurse responsible for completing the 8/15/20 assessment was not possible. An interview was conducted with the facility Administrator on 2/5/21 at 11:02 AM. The Administrator new diagnoses were discussed in weekly meetings and the diagnoses were to be	F 641	1. The specific deficiency was corrected on 2/25/2021 by modifying the MDS with an Assessment Reference Date of 8/15/2021 and adding the diagnosis of Congestive Heart Failure to Section 1. This was completed by the MDS Nurse Consultant. The corrected MDS was re-submitted to State Database on 2/25/2021 in Batch #202. 2. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of the most recent physician progress note for each resident was completed on 2/12/2021 by the Health Information Manager. Any progress note found to have a new or additional diagnosis of Congestive Heart Failure was added to the diagnosis list with attached ICD-10 Code. A 100% audit of the Minimum Data Set assessments for all residents who currently have a diagnosis of Congestive Heart Failure was completed on 3/1/2021 by the MDS Education and Compliance Consultant in order to ensure that Section 1 was accurately coded on the most recent Minimum Data Set assessment. All new diagnosis of Congestive Heart Failure as of 3/1/2021 will be coded on the next scheduled Minimum Data Set assessment or Significant Change assessment. 3. On 2/26/21, the MDS Education and Compliance Consultant completed an in-service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record prior to completion of	

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F 641	Continued From page 8 entered into the electronic health record where the MDS nurse would be able to capture it for the assessment. She added the person responsible for entering the information into the electronic health record was new to her role and must have missed entering the new diagnosis for Resident #1.	F 641	Section 1 (Active Diagnosis) of the Minimum Data Set assessment. Steps for accurately determining and coding active diagnoses were reviewed based on direction given by the Resident Assessment Instrument Manual. 4. The Director of Nursing or designated Nurse Manager will begin auditing the coding of Section 1 (Active Diagnoses) of the most recent Minimum Data Set Assessment for five residents weekly x 1 month then monthly x 2 months. Findings will be presented to the QA Committee monthly x 3 months and ongoing as needed to assure compliance. The Administrator and the Director of Nursing will be responsible for implementing the acceptable plan of correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		3/1/21

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F 656	Continued From page 9 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan in the area of nutrition for 1 of 2 residents reviewed (Resident #2). The findings included: Resident #2 was admitted to the facility on 6/29/2020. Resident #2's comprehensive minimum data set (MDS), dated 6/29/2020, revealed the Resident's admission diagnosis included Anemia, diuretic	F 656	1. Affected resident was discharged prior to this survey. 2. On 2/9/2021, all resident care plans were audited by MDS Support RN to assure nutritional status has been addressed. Residents with no care plan addressing nutritional status were identified and care plans updated by Food Service Director prior to 2/12/21. 3. Food Service Director re-educated on 2/9/21 by Administrator to assure	

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F 656	Continued From page 10 therapy, Vascular dementia, depression, Chronic ulcer/wound to the ankle and disorders of lipoprotein metabolism. The Resident was coded to require one-person limited assistance with eating and a weight of 168.9 pounds (lbs.). The Care area assessment summary (CAA) triggered the Resident to be care planned for nutritional status. The nutritional status care plan recommendation was coded that the area would be included in the care plan. The Physician (MD) progress notes revealed the MD had assessed Resident #2 on 6/30/2020. The MD documented the Resident had a rapid decline in health over the past year and ordered a nutrition supplement, Prostat 30 milliliters three times a day, based on a recent decrease in food intake. The assessments revealed the Registered Dietitian (RD) assessed Resident #2 on 7/1/2020 and included a progress note that stated Resident #2 had poor food intake. The RD recommended the Resident maintain a weight of 175 lbs. and to continue to monitor and add to the plan of care. The RD added that she had the ability to add a focus on the care plan or update the care plan for a resident, however, it was the standard practice of the facility for the Minimum data set (MDS) coordinator to manage the plan of care. Resident #2's plan of care, dated 7/6/2020, did not include a nutritional focus area. An interview was conducted on 2/3/2021 at 10:35 a.m. with the MDS nurse and revealed that she was not the MDS nurse during June and July of 2020. She stated that if an area was identified on	F 656	nutritional status for all current residents and all new admissions be care planned. 4. Director of Nursing or MDS Support RN will audit resident care plans 1 x weekly x 1 month then 1 x monthly x 2 months to assure nutritional care plan in place and present for QA Committee review monthly x 3 months and ongoing as needed. Administrator will be responsible for implementing the acceptable plan of correction.	

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F 656	Continued From page 11	F 656		

a CAA and coded that it was going to be added to the care plan, she would include it as a focus area on a resident's care plan. The MDS nurse reviewed the care plan for Resident #2 and stated she did not see a nutritional focus.

An interview was conducted on 2/3/2021 at 11:18 a.m. with the restorative nursing assistant. She stated that Resident #2 had weekly weights during the month of July 2020. She revealed the weights had been provided to the weights committee and the weights committee would then document the weight, make recommendations, and notify the family, physician and dietician as needed. She stated the intervention to continue weekly weights for Resident #2 was recommended to continue, on 7/28/2020, due to the amount of weight loss since admission.

An interview was conducted with the Director of Nursing (DON) on 2/3/2021 at 11:45 a.m. and she stated it was her expectation that a resident with poor intake or significant weight changes have a care plan for nutrition. The DON stated the weight committee reviewed Resident #2 during the month of July 2020 and made a recommendation to continue to monitor the Resident due to a loss of weight.

Review of the restorative aide's documentation of weekly weights for Resident #2, revealed the Resident weighed 168.9 on 6/30/2020, 158.4 lbs. on 7/16/2020, 158.1 lbs. on 7/21/2020 and 150.1 lbs. on 7/28/2020. Based on this documentation, a weight loss of 6% occurred from the date of 6/30/2020 to 7/16/2020. A weight loss of 11% occurred in less than 30 days.

Resident #2 was discharged on 8/7/2020.

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YADKIN NURSING CARE CENTER	903 W MAIN STREET YADKINVILLE, NC 27055

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update the care plan to include a new diagnosis of congestive heart failure (CHF) for 1 of 2 residents reviewed (Resident #1). The findings included: Resident #1 was admitted to the facility on 5/8/20	F 657	1. Affected resident was discharged prior to this survey. 2. On 3/1/2021, the care plans for all residents with a diagnosis of Congestive Heart Failure were audited by MDS Education and Compliance Consultant to ensure an active care plan is in place to	3/1/21

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with a diagnosis of left hip fracture.

A nurse ' s note dated 7/15/20 at 3:43 PM read, "resident complaining of congestion and cough, bilateral lungs have scattered crackles, oxygen saturation level 97 percent on room air. Spoke with physician regarding ordering chest xray. Xray order obtained and called in".

Results of the ordered chest xray ordered 7/15/20 revealed "mild pulmonary infiltrate in the left lung base and small left pleural effusion was present consistent with congestive heart failure (CHF) versus pneumonia".

A review of a physician ' s progress note dated 7/16/20 revealed a new diagnosis of CHF.

A review of the resident ' s current care plan, which was updated by staff on 9/10/20, revealed the care plan was not updated to include the new diagnosis of CHF.

An interview was conducted with Minimum Data Set (MDS) Nurse #1 on 2/3/21 at 2:30 PM who stated new orders would be put in a box at the nurse ' s station for the MDS nurse to review and add to the care plan. She added a new diagnosis of CHF that required daily medication and weight monitoring, should have been added to the resident ' s care plan as a new problem with goals and interventions for care.

An interview was conducted with the facility Administrator on 2/45/21 at 11:02 AM. The Administrator stated typically new diagnoses would be entered into the electronic health record and then would be captured by the MDS nurse. She added this step must have been missed and

reflect diagnosis with appropriate interventions. Residents identified without active CHF care plans were corrected on 3/1/2021 by the MDS Education and Compliance Consultant.

3. Minimum Data Set Assessment Nurse was educated on 2/26/21 by MDS Education and Compliance Consultant on the importance of maintaining up-to-date care plans that are reflective of the resident's current status and as needs change.

4. Director of Nursing or nurse manager designee will audit resident care plans 1 x weekly x 1 month then 1 x monthly x 2 months to assure resident's with new diagnosis of Congestive Heart Failure have an active care plan in place to reflect diagnosis. Findings will be presented to QA Committee for review monthly x 3 months and ongoing as needed. Administrator will be responsible for implementing the acceptable plan of correction.

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F 657	Continued From page 14 the new diagnosis of CHF for Resident #1 did not get added to the resident ' s MDS or care plan.	F 657		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Responsible party, physician and registered dietician (RD) interviews, the facility failed to provide interventions for a resident with identified significant weight loss (Resident #2). This was evident in 1 of 2 residents reviewed for nutrition. Findings included: Resident #2 was admitted to the facility on	F 692	1.Resident discharged prior to notification of significant weight loss. 2. On 2/11/2021, a weight committee meeting was held with the Director of Nursing, Staff Development Coordinator, Food Service Director and LPN Unit Manager. All weights for January & February 2021 were reviewed for all current residents to assure each had	3/1/21

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6/29/2020.

Resident #2's comprehensive minimum data set (MDS), dated 6/29/2020, revealed the Resident's admission diagnosis included anemia, diuretic therapy, vascular dementia, depression, chronic ulcer/wound to the ankle and disorders of lipoprotein metabolism. The Resident was coded to have moderate cognitive impairment, required one-person limited assistance with eating and a weight of 168.9 pounds (lbs.).

The Care area assessment summary (CAA) triggered the Resident to be care planned for nutritional status. The nutritional status care plan recommendation was coded that the area would be included in the care plan.

The Physician (MD) progress notes revealed the MD had assessed Resident #2 on 6/30/2020. The MD documented the Resident had a rapid decline in health over the past year and ordered Pro Stat (liquid protein nutritional supplement), 30 ml three times a day, based on a recent decrease in food intake. He added to monitor the resident for changes related to diuretic and hypertensive therapy combined with poor intake.

Review of Resident #2's medical orders revealed a diuretic, Torsemide, 20 mg once day was ordered on admission, dated 6/29/2020 and Prostat 30 ml, three times a day was ordered on 6/30/2020 by the facility medical director.

Review of Resident #2's plan of care, dated 7/6/2020, included a focus area for being at risk for dehydration r/t diuretic therapy with interventions that included to monitor for interactions/adverse consequences and monitor

F 692

recorded weights. On 2/25/2021, the Director of Nursing compared most recent resident weights to assess for significant weight loss (>5% in 30 days and >10% in 180 days). By 3/1/21 the physician, the responsible party and Registered Dietician will notified of most recent significant weight losses by Food Service Director. Registered Dietician and physician to review and suggest or order interventions.

3. On 3/1/2021, the Food Service Director was re-educated by the Director of Nursing on the importance of notifying the registered dietician, the responsible party and the physician of significant weight losses no less than weekly.

4. One x weekly x 1 month and 1 x monthly x 2 months the Director of Nursing or Nurse Manager Designee will audit residents identified in weekly weight committee meeting as having significant weight loss to assure that Food Service Director has notified the physician, the responsible party and the Registered Dietician of significant weight loss. Findings will be reported to QA Committee monthly x 3 months and ongoing as needed. The Administrator will be responsible for implementing the acceptable plan of correction.

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for possible side effects every shift. A focus area for antidepressant medication with increased risk for adverse side effects of depression was documented. The interventions included to observe and report to the MD as needed ongoing signs and symptoms of depression unaltered by antidepressant meds and report to the nurse the following, decreased appetite, confusion, mood change, change in normal behavior, decline in ability to help with activities of daily living. The care plan did not include a focus area for at risk for altered nutritional status.

Review of the assessments revealed the Registered Dietitian (RD) assessed Resident #2 on 7/1/2020 and included a progress note that stated Resident #2 had poor food intake. The RD recommended the Resident maintain a weight of 175 lbs. and to continue to monitor and add to the plan of care. The RD documented the resident weight as 184 lbs.

Review of the weights in the electronic medical record for Resident #2 documented a weight on admission, 6/30/2020, of 168.9 pounds (lbs.), on 7/1/2020 of 184.0 lbs. and on 7/30/2020 of 150.1 lbs.

A review of documentation provided by the restorative nursing program and stored in an office filing cabinet revealed additional weight results for the Resident on 7/16/2020 of 158.4 lbs., on 7/21/2020 of 158.1 lbs. and on 7/28/2020 of 150.1 lbs.

A telephonic interview was conducted with the responsible party (RP) for Resident #2 on 2/2/2021 at 2:04 p.m. The RP denied receiving any information regarding weight loss of the

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F 692	Continued From page 17 resident. She stated therapy staff would notify her that the resident had not been eating much. She added that she was not included in planning resident specific interventions. An interview was conducted on 2/3/2021 at 10:35 a.m. with the MDS nurse and revealed that she was not the MDS nurse during June and July of 2020. She stated that if an area was identified on a CAA and coded that it was going to be added to the care plan, she would include it as a focus area on a resident's care plan. The MDS nurse reviewed the care plan for Resident #2 and stated she did not see a nutritional focus with recommended interventions. An interview was conducted on 2/3/2021 at 11:18 a.m. with the restorative nursing assistant. She stated that Resident #2 had weekly weights during the month of July 2020. She revealed the weights had been provided to the weights committee and the weights committee would then document the weight, make recommendations for interventions, and notify the family, physician and dietician as needed. She stated the intervention to continue weekly weights for Resident #2 was recommended to continue, on 7/28/2020, due to the amount of weight loss since admission. An interview was conducted with the Director of Nursing (DON) on 2/3/2021 at 11:45 a.m. and she stated it was her expectation that a resident with poor intake or significant weight changes have a care plan for nutrition with interventions from the Interdisciplinary team (IDT). The DON added the IDT for the facility consist of the weight committee, the medical director and the RD. The DON stated the committee reviewed Resident #2 for the initial weight loss, dated 7/16/2020, and	F 692		

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determined the 5% loss could be from diuretic therapy in the facility and intravenous therapy at the hospital, prior to admission. An intervention to continue to monitor was recommended by the team due to weight loss. The DON added that Resident #2 was discussed on the date of her discharge, 8/7/2020, and that interventions for weight loss had been recommended, that included, supplements, weekly weights and an RD evaluation.

Review of the restorative aide's documentation of weekly weights for Resident #2, revealed the Resident weighed 168.9 on 6/30/2020, 158.4 lbs. on 7/16/2020, 158.1 lbs. on 7/21/2020 and 150.1 lbs. on 7/28/2020. Based on this documentation, a weight loss of 6% occurred from the date of 6/30/2020 to 7/16/2020. A weight loss of 11% occurred in less than 30 days.

A telephonic interview was conducted with the RD, on 2/5/2021 at 11:47 a.m. She stated that the COVID-19 pandemic prevented in person visits and that she relied on accurate documentation of a weight to carry out an assessment. She stated the only weight available for the assessment of Resident #2, on 7/1/2020, was a weight of 184 lbs. in the electronic system titled, PCC, and the weight had been documented by the facility dietary manager from the Hospital discharge summary and facility admission paperwork. She stated the admission weight of 168.9, on 6/30/2020 was documented in PCC after her assessment, as a late entry. She revealed the facility process was for the weights committee to send an email to notify the RD of wounds and significant weight loss. She denied receiving notification of the inaccuracy of the weight, dated 7/1/2020, and denied receiving notification of

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weight loss during the month of July 2020 for Resident #2. The RD added that it was her expectation to receive notification for significant weight loss and that included anything greater than 5%. She stated she would make recommendations for interventions that were individualized for a resident once she received notification.

A telephonic interview was conducted with the MD, on 2/5/2021 at 1:48 p.m. and he stated that he had seen Resident #2 on 6/30/2020 and again on 8/7/2020. He denied receiving any notification of significant weight loss prior to the Resident's discharge on 08/07/20. He stated it was his expectation that any weight loss of greater than 5% in one month be reported to the MD for evaluation. He stated he was utilizing PCC documentation in July of 2020 and relied on accurate and timely documentation during visits. He denied having access to, or knowledge of, the weights documented by the restorative nursing assistant in July 2020. He stated he expected the facility to be aware of the federal regulations regarding the definition of significant weight loss, would educate the facility of his expectation for notifications and that he required a list of all areas that documentation was to be stored if not in the PCC system. He added that notification was necessary, between in person visits, to know when additional supplements, medication adjustments and other interventions are needed.

Resident #2 was discharged to the emergency room on 8/07/2020 for a severe urinary tract infection and did not return to the facility.

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/1/21

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F 880	Continued From page 20 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and 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; §483.80(a)(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:	F 880		

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F 880	Continued From page 21 (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 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, staff interviews and review of the facility's Policy titled, "COVID-19 Preparation and Response," the facility failed to implement their COVID-19 policy on preforming hand hygiene when a staff member (nursing assistant #1) failed to perform hand hygiene while delivering meal trays to 3 of 3 residents (Resident #3, #4 and #5). This failure occurred during a COVID-19 pandemic. The findings included:	F 880	1. On 2/26/2021, residents #3, #4, and #5 were assessed by the Director of Nursing and there were no S&S of infection. 2. All residents not previously diagnosed with COVID-19 were tested on 2/22/21 and no new cases of COVID -19 were detected. 3. On 2/3/2021, CNA #1 was re-educated on the importance of hand hygiene while	

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F 880	Continued From page 22 A review was conducted of the facility policy Titled, "COVID-19 Preparation and Response," revised 2/5/2021. The policy specified that all employees will perform hand hygiene prior to entering a resident's room and upon exit. On 2/3/2021 at 12:15 p.m. a meal observation was conducted on the 700 hall. Nursing Assistant (NA) #1 carried a meal tray into Resident #4's room, placed the meal tray on the bedside table for the Resident, then removed the lid from the drink and plate. NA #1 exited the room without performing hand hygiene. On 2/3/2021 at 12:17 p.m. NA #1 was observed to walk from Resident #4's room to the meal delivery cart in the hall, remove another tray and walk into Resident #5's room without performing hand hygiene. The NA was observed to place the meal tray on the bedside table, remove the covering over the food and place the silverware and napkin within reach of Resident #5. The NA then exited the room without performing hand hygiene. On 2/3/2021 at 12:20 p.m. NA #1 was observed to walk from Resident #5's room to the meal delivery cart, remove a tray and walk into Resident #3's room without performing hand hygiene. The NA placed the tray on the bedside table for Resident #3 and removed the lid from the drink and the plate covering. The NA assisted Resident #3 to sit on the side of the bed by placing her arm under the resident's shoulder. The NA then exited the room without preforming hand hygiene. The observation revealed a hand sanitizer dispenser was available in the hall, within 10 feet of the three residents' rooms	F 880	passing meal trays. A 100% facility staff in-service will be completed by 3-1-2021 on the importance of hand hygiene while passing meal trays and during any resident care that requires hand hygiene. Any staff member unable to complete education will not be allowed to work until education completed. On 2/23/21, the Director of Nursing and Infection Control Practitioner initiated the CDC Clean Hands Video https://youtu.be/xmYMUly7qiE training for all facility registered nurses, licensed practical nurses, medication aides, nurse aides, support aides, and agency staff to meet the requirements of the directed plan of correction. Any nursing staff unable to complete video on or before 3/1/2021 will not be allowed to work until video is completed. Remaining facility staff to complete video by 3/1/2021. Any staff member that has not viewed video will not be allowed to work until video training is completed. On 2/24/21 the QA Nurse Consultant, Director of Nursing, Infection Control Practitioner, MDS Registered Nurse completed a root cause analysis of the hand hygiene failure using the 5 Whys. The root cause was determined to be agency nurse aide human error related to survey anxiety. On 3/1/21 the Staff Development Coordinator educated nurse aide #1 agency staff using updated agency nurse and aide orientation checklist to the facility that included relaxation techniques when experiencing periods of personal anxiety and fear when confronted by stressful	

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 02/05/2021

NAME OF PROVIDER OR SUPPLIER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23 (Resident #3, #4 and #5) and inside of each room there was a sanitizer dispenser and a sink. On 2/3/2021 at 12:22 p.m. an interview was conducted with NA #1. She revealed that the facility policy was to wash hands or sanitize prior to entering a resident room and when leaving the room. She stated she had been in a hurry to deliver the trays and forgot to use hand sanitizer for a few rooms. On 2/3/2021 at 12:25 p.m. an interview was conducted with the infection control nurse. She revealed that the facility policy was to perform hand hygiene when entering or exiting a resident room, before and after providing direct patient care and when hands are visibly soiled during resident care. She stated it was her expectation that staff complete hand hygiene per the facility policy. The nurse then stated she was going to provide education to NA #1 regarding hand hygiene. On 2/3/2021 at 1:15 p.m. an interview was conducted with the Director of Nursing and she stated her expectation was for staff to conduct hand hygiene per the facility policy.	F 880	situations as a result of root analysis. 4. The Director of Nursing or the Infection Control Practitioner will perform surveillance of hand hygiene by five facility and agency staff members during meal service to assure appropriate hand hygiene is being performed while trays are being passed and with any resident care requiring hand hygiene 1 x weekly x 3 months. Findings will be reported to the QA Committee 1 x monthly x 3 months and ongoing as needed. The Administrator is responsible for implementing the accepted plan of correction.	