STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G166	A. BUILDING _____ B. WING _____	R 01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN II & III	3220 & 3224 US HWY 21 HAMPTONVILLE, NC 27020

(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
W 000	INITIAL COMMENTS A revisit was conducted on 1/5/2026 for all previous deficiencies cited on 8/13/2025. One of eight deficiencies were not corrected and will be re-cited.	W 000		
{W 454}	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: A follow up survey was completed on 1/5/26. The facility failed to provide supporting documentation relative to the information submitted in the plan of correction (POC). The deficiency is re-cited. Based on observations and interviews, the facility failed to ensure the potential for cross-contamination was prevented relative to 1 audited client (#10) in Yadkin III facility. The finding is: Observations in the group home on 8/13/25 at 7:05AM revealed client #10 to sit in the bathroom while toileting with the door open. Further observations at 7:07 AM revealed client #10 to pull up her pants and leave out of the bathroom without wiping or washing her hands. Continued observations revealed client #10 to lay in her bed. Subsequent observations at 7:50 AM revealed staff to call client #10 to the medication room for medication administration. Further observations revealed client #10 to participate in medication	{W 454}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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
{W 454}	Continued From page 1 administration without washing or sanitizing her hands. Interview with the qualified intellectual disabilities professional (QIDP) on 8/13/25 revealed staff should have monitored client #10 in the bathroom to ensure that she wiped herself and washed her hands. Further interview with the QIDP verified staff have been trained to make sure clients wash their hands after toileting and prior to medication administration.	{W 454}		