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 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN NURSING CARE CENTER	903 W MAIN STREET BOX 879 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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews the facility failed to maintain the walls, tile floors, and shower chairs in a safe and sanitary manner in three of four shower rooms. The facility failed to maintain resident equipment in good condition in for five of eighteen sampled residents (Residents # 132, 90, 76, 103 and 133). The findings included: 1. An observation of the 300 hall shower room #2 on 10/21/2015 at 1:58 PM revealed 6 cracked and loose tiles on the floor and walls of the shower stall. There were no sharp edges noted. Six tiles had become loose and were piled in the drain area of the shower stall. On 10/22/2015 at 12:32 PM, an environmental tour was conducted with the Maintenance Director, Housekeeping Supervisor, and Director of Nurses (DON). The tour included an observation of the missing and cracked tiles on the walls and floor of the shower stall in shower room #2 on the 300 hall. The Maintenance Director stated that he had previously attempted to repair many tiles in the shower room at various times over the past few months and that it was very difficult to get the tiles to adhere to the floors or walls in the shower rooms because the base flooring under the tiles was aged and holding moisture. The DON stated that a contracted plumber was also coming to the facility to assist them with the moisture and tile repairs his most	F 253	STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the alleged deficient practice(s). For residents specifically identified by this deficient practice, the facility has completed the following: 1. The missing tiles noted in shower room #'s 2 and 3, located on the 300 and 500 halls, respectively, have been replaced and remain in-tact. Similarly, the door of shower room #3 on 500 hall opens without impediment. 2. The paint in shower room #3 has been repaired, and the rings to the privacy curtain have been cleaned and/or replaced. Additionally, the wheelchair scale has been cleaned and paint has been re-touched. The two shower chairs noted in shower room #3 have been cleaned, repaired and/or replaced. 3. Floor mats for Resident #'s 76, 132, 133, and 103 have been replaced. The	11/20/15

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

Electronically Signed | 11/13/2015

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F 253	Continued From page 1 recent facility visit was 10/21/2015. The DON stated that her expectations were to repair failing shower room tiles as soon as she could schedule repairs. 2. a. An observation of shower room # 3 on the 500 hall on 10/21/2015 at 2:04 PM disclosed that upon entering shower room #3, that the nonskid mat on the inside of the door was very close to the door making the door rub tightly against the mat and the need for excessive force to open and close the door safely. The paint was chipped and peeling on the wall near the light switch inside of the shower room. Tiles were loose and cracked in the shower stall. There was no privacy curtain hung at the shower stall entrance and the clear plastic shower rings were encased in dirt and in disrepair with cracks and broken attachment hooks. The base of the bathtub was missing tiles at the corners of the tub base exposing jagged rough concrete block edges. The wheelchair scale stationed next to the bath tub had peeling paint and was rusted in areas. The scale base touching the floor was crusted with dirt. An environmental tour of shower room #3 was completed on 10/22/2015 at 12:36 PM and included the Maintenance Director, the DON and the Housekeeping Supervisor. The Maintenance Director also verified that he was not aware of the missing tiles covering the base of the bath tub and stated that he was very concerned about the potential safety hazard of missing and cracked tiles at the tub base or in the shower stall and he would repair them that evening. b. Shower room # 3 was also observed to be crowded with six shower chairs two of which were in visible disrepair with the mesh seats and back rests torn and shredded with ragged edges hanging loosely to the floor. The mesh as well as the PVC piping chair bases appeared to have dirt	F 253	chair cushion for Resident #103 has been replaced. The side-rail foam for Resident #90 has been replaced and fits appropriately. All resident care spaces and resident care equipment currently in use in resident rooms have been inspected by the Housekeeping Director, Maintenance Director and Director of Nursing.Any spaces requiring maintenance-related repairs have been completed. Any resident care spaces and resident care equipment currently in use requiring cleaning has been cleaned appropriately. For all other residents having the potential to be affected by this deficient practice, and to ensure compliance, the Housekeeping Director and Maintenance Director, or designee, shall conduct a daily visual inspection of all resident care spaces and resident care equipment, which shall include any items currently in use by each resident, and remediate any noted issues. Evidence of the daily visual inspections by both the Housekeeping Director and Maintenance, or designee, shall be noted on the record of Daily Visual Inspection Report. Identified issues shall be noted thereon. Subsequently, the identified issue is corrected shall also be noted. Resident care spaces and resident care equipment that cannot be cleaned or repaired may be taken out of service until such remediation may occur. Visual inspections shall occur daily for two weeks, weekly for four weeks, and monthly thereafter. The	

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F 253	Continued From page 2 or rust stains under the seats and at pipe connection junctures. An environmental tour of shower room #3 was completed on 10/22/2015 at 12:36 PM and included the Maintenance Director, the DON and the Housekeeping Supervisor. The Housekeeping Supervisor stated that she would replace the shower curtain and rings. It was revealed that a shower chair cleaning schedule was in place to be completed weekly and as needed by her. Replacing and repairing the mesh chair covers was also an integrated part of this schedule. An interview on 10/22/2015 at 2:08 PM with the contracted plumber who was in the facility, revealed that he had no set schedule for coming to the facility and that he only came when called by the DON and as he was able. The plumber stated that he strictly addressed plumbing concerns such as pipe leaks, water pressure concerns and such and he was not involved in any tile work or any structural repairs or renovations. 3. a. Observations of the residents ' rooms revealed the floor mats were in disrepair. Observations on 10/19/15 at 2:20 PM revealed Resident #76 ' s floor mat with rips/tears on the top of the mat with one corner missing the foam and covering. Observations on 10/19/15 at 2:40 PM revealed Resident #132 ' s floor mat had rips and tears on the top of the mat. Observations on 10/20/15 at 8:52 AM revealed Resident #133 ' s floor mat was frayed/ripped. Observations on 10/20/15 at 1:28 PM Resident #103 ' s floor mat had tears and rips on the top of the mat. b .Observations of a chair cushion (cloth padded cushion) for Resident #103 revealed it	F 253	Director of Nursing and/or Administrator or their senior management designee, shall make visual inspections weekly for four weeks and monthly thereafter. All residents Evidence of such weekly visual inspections conducted by the Director of Nursing and/or Administrator or their senior management designee, shall be noted on the Facility Administration Physical Plan & Resident Care Equipment Inspection Record. Issues identified thereon shall include an expected remediation date. Additionally, all staff have received inservice education related to the importance of reporting maintenance- and/or housekeeping-related issues. All staff have received inservice education related to the facility□s established practice of completing work-orders for maintenance-and/or housekeeping- related issues. The previously enacted Quality Assurance procedures related to physical plant maintenance and housekeeping was not effective to ensure substantial compliance. Accordingly, each report identified herein shall be reviewed by the Quality Assurance Committee monthly for 12 □ consecutive months. Subsequently, the facility shall re-evaluate the facility□s ability to ensure substantial compliance, specific to this identified deficient practice. In part, the facility shall evaluate the efficacy of the inspection and reporting regimen described herein at least quarterly. Such evaluations shall include a reconciliation of items identified to the items remediated.	

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F 253	Continued From page 3	F 253		

was in disrepair. Observations on 10/20/15 at 1:28 PM revealed Resident #103 ' s chair padding on the inside of the chair ' s back, seat and armrests was frayed, torn and had a hole in one end with the batting coming out.

c. Observations of the side rail foam covering Resident #90's side rails revealed it was torn and loose from the bars of the side rails. Observations on 10/20/2015 at 3:26 PM revealed Resident #90 had foam covering taped to the bars of the side rails on both sides of the bed.

Observations and tour were made with the Director of Nursing (DON), Maintenance Director and Housekeeping Director on 10/22/15 at 12:40 PM. The equipment observed during survey had remained unchanged and was in disrepair. Interview with the DON during tour revealed the mats were not replaced all at once due to cost. Further interview revealed the mats were removed from the floor when the residents were out of bed to prevent further damage from wheelchairs.

Interview with Resident #90 on 10/22/15 at 12:45 PM revealed it had " been there " since she came. She had asked for tape to fix it herself. Resident #90 was admitted to the facility on 7/22/15.

Interview with the Maintenance Director on 10/22/15 at 12:50 PM revealed he had not received information regarding the loose foam covering on the side rails of the bed. He and housekeeping worked together with issues in rooms to be aware of what might be wrong.

Interview on 10/22/15 at 1:00 PM with the

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F 253	Continued From page 4 Housekeeping Director revealed the padding (chair cushion) under Resident # 103 was not inspected during laundry. She further explained the padding would not have been showing through the ripped seam while hanging up to dry. She would repair items when possible, but would definitely discard when torn and frayed. She was not aware of the condition of this padding. The Housekeeping Director explained the laundry person should check the cushions and it should have been discarded. Interview with the DON on 10/22/15 at 1:10 PM revealed she would expect the aides to notice if the padding was frayed. She would expect the aides to inform the housekeeping staff remove it and take care of it on the day it was noticed.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280		11/20/15

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F 280	Continued From page 5 each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to update new interventions, problems and approaches on care plans for three of eighteen sampled residents. (Resident #66, 59 and 117) The findings included: 1. Resident #66 was admitted to the facility on 4/14/15 with diagnosis of hypertension, diabetes, glaucoma, and a history of stroke. The Minimum Data Set (MDS) a quarterly dated 7/17/15 indicated the resident had severe impairment with long and short term memory impairment, behaviors of verbal and physical were occurring towards others. The resident required physical assistance of 2 persons for ambulation, total dependence for bed mobility and transfers and extensive assistance for dressing and hygiene. There were no restraints in use during this assessment timeframe. The resident's current care plan with an update of 7/29/15 did not address the use of a restraint. Review of the physician's order dated 9/13/15 included the use of a lap buddy as a restraint. Observations on 10/20/2015 at 9:46 AM revealed the lap buddy remained on Resident #66 ' s Geri chair during an activity where staff were providing the resident with 1:1 with nail care.	F 280	STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Resident #66□s care plan has been updated to include the use of the lap buddy. Resident #117□s care plan has been updated to reflect the resident□s current medication regimen. Similarly, Resident #117□s care plan has been updated to include approaches to prevent and/or minimize 1) physical behaviors and 2) resisting care. Resident #59□s care plan has been updated to include 1) behaviors of wandering, 2) suicidal ideations, 3) trichotillomania (i.e. skin excoriation disorder), 3) anxiety, and 3) being aggressive with staff, and hallucinations about the resident□s mother. For those residents having the potential to be affected by the alleged deficient practice and to ensure compliance, the facility□s MDS Nurses have reviewed all active residents□ care plans and MDS□s	

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F 280	Continued From page 6 Interview with the MDS Coordinator on 10/21/2015 at 10:17AM revealed she had not updated the care plan. She explained the lap buddy was a new intervention for fall prevention. The process for her to be aware of new interventions included information shared at a "patients at risk" (PAR) meeting. During the interview she reviewed her notes from the meeting held on 9/30/15 and was informed about the lap buddy being used by Resident #66. During the interview she explained it Resident #66 ' s care plan should have been updated for the use of the lap buddy. 2. Resident #117 was admitted to the facility on 3/13/13. The diagnoses included anxiety and hypertension. Review of the Minimum Data Set (MDS) dated 7/10/15, a quarterly indicated Resident #117 had severe impairment with long and short term memory and behaviors of rejection of care, verbal and physical aggression towards others. The resident's current care plan that was updated on 7/22/15, included a problem for potential side effects from medications. The problem was related to the resident was taking Risperdal (antipsychotic) and Ativan (antianxiety). This care plan indicated a problem of verbally abusive to staff. Review of the care plan did not include physical behaviors, rejection of care and the changes in medication for possible side effects. Review of the current physician's monthly orders on 10/21/15 revealed Resident #117 was no longer receiving Risperdal. The medication had been discontinued on 3/20/15 with a new medication added Depakote (mood stabilizer). Interview with the MDS nurse on 10/21/2015 at	F 280	to ensure the care plans are up-to-date and adequately address current problems and associated approaches and/or interventions specific to the care of each resident. Evidence of such review shall be documented on the Resident Care Plan Audit, which shall include only issues identified that are not included in the resident□s current care plan. The Director of Nursing has conducted an inservice with the MDS Nurses and the entire multidisciplinary team which includes facility social worker(s), Activities Director, and Dietary Director related to the regulatory expectation that care plans are updated with relevant information specific to the individual needs of each resident. All resident care plans shall be audited monthly for three months and no less than quarterly thereafter to ensure all relevant problems, approaches and/or interventions are included in the care plan. The results of the Resident Care Plan Audit shall be presented for review by the Quality Assurance Committee monthly and quarterly thereafter.	

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1:41 PM revealed Resident #117 ' s care plan had not been updated to reflect the discontinued use of Risperdal and addition of Depakote. Further interview revealed the care plan had been completed by a nurse who was not available for interview. The care plan had not been updated to include the behaviors of physically aggressive and resistive to care. The MDS nurse explained the resident ' s care plan should have been updated.

3. A physician ' s note dated 5/20/15 revealed Resident #59 ' s staff member had asked the medical doctor to check on the Resident because she had been more anxious lately. The note stated Resident #59 had gone through a Risperdal taper over the past couple of weeks, and she was off the medication now. Resident #59 had been on both Risperdal and Seroquel. The note indicated these medications were started by her psychiatrist with multiple other antipsychotics and anxiolytics. Resident #59 was also on Klonopin (antipsychotic) and she also takes Cogentin (a drug to treat Parkinson ' s). The note indicated the medical doctor recommended keeping Resident #59 off of Risperdal. The note stated Resident #59 would have a psychiatric follow up and in the meantime, the facility would change her Seroquel to 50 milligrams (mg) by mouth three times a day starting 5/21/15 and monitor behavior.
Review of the Transfer/discharge form dated 6/29/15 indicated Resident #59 was at risk for injury to self and others.
Physician note dated 6/29/15 revealed Resident #59 was noted to have agitation/schizoaffective behavior exacerbation after stopping Risperdal to avoid poly-pharmacy. She also had been on

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Seroquel. She was seen by her psychiatrist last week, and staff reported that since the medication adjustments that she seemed to be much calmer. The note further indicated psychiatry requested that nobody else adjust her antipsychotics except their service.
Review of transfer/discharge form dated 6/30/15 indicated resident #59 had increased anxiety, restlessness and attempted to place head in toilet. The resident told the staff member, " she was trying to hurt herself. " The note revealed Resident #59 had a urinary tract infection (UTI). The note stated " Resident behavior has increased prior to (UTI). Resident at risk of harming self or others. "
A readmission history and physical (H&P) dated 7/16/15 revealed Resident #59 was hospitalized with mental status changes, and she was diagnosed with acute exacerbation of chronic paranoid schizophrenia with mild dementia.
A care plan meeting note dated 7/23/15 indicated behaviors were discussed to include picking at skin, delusions, hallucinations about mother and pulling at the air conditioning unit.
Review of the quarterly Minimum Data Set (MDS) dated 7/26/15 indicated Resident #59 had behaviors to include hallucinations, delusions, and physical behavioral symptoms directed at others, and wandering.
Resident #59 ' s current care plan that was last updated on 7/26/15 indicated a problem of resident was taking psychotropic medications related to schizoaffective disorder and has a potential for drug related side effects related to resident being prescribed Seroquel (antipsychotic), Risperdal (antipsychotic), Clorazepate (antianxiety) , Zoloft (antidepressant) and PRN Ativan (antianxiety). The goals included Resident would not experience adverse side

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F 280	Continued From page 9 effects and Resident would benefit from medication regimen. Review of the problems did not include Resident #59 ' s behaviors such as hallucinations, wandering, and anxiety, aggressive with staff, and suicidal ideations. Interview with the MDS Nurse on 10/22/15 at 12:45pm revealed Resident #59 ' s care plan had not been updated to reflect the adjustments to Resident #59 ' s psychoactive medications. The MDS had been completed by a nurse who was not available for interview. The care plan had not been updated to include behaviors of wandering, suicidal ideations, skin picking, anxiety, being aggressive with staff, and hallucinations about her mother. The MDS nurse stated Resident #59 care plan should have been updated.	F 280		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to	F 356		11/20/15

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F 356	Continued From page 10 residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post the required nurse staffing data for 4 of 5 days of the annual recertification survey conducted 10/19-10/23/15. The findings included: During the initial tour of the facility on 10/19/15 the " Daily Facility Staffing " form was observed to be posted at the front entrance to include the facility name, current date, total number of nursing staff and the census. The " Daily Facility Staffing " did not include the actual hours and it was posted for all 3 shifts. An observation for 4 consecutive days 10/19/15, 10/20/15, 10/21/15 and 10/22/15 at 10:00AM revealed a posting each morning to include all 3 shifts and did not include the actual hours worked for licensed and unlicensed nursing staff. During an interview with the schedule coordinator on 10/22/15 at 1:05 PM who is responsible for posting the " Daily Facility Staffing " indicated that each morning she posted the " Daily Facility Staffing " and made sure it included the date, census, number of licensed and unlicensed nursing staff and provided the data for all 3 shifts. She further indicated that she was not aware that	F 356	STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). No residents were specifically identified as having been affected by the same alleged deficient practice. For those residents having the potential to be affected by the alleged deficient practice, the individual staff member(s) responsible for accurately posting the identified information, have received the education needed in order to know the correct information to post. All subsequent postings shall have the required information including numbers of licensed and unlicensed staff, the numbers of hours worked, and census.	

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YADKIN NURSING CARE CENTER	903 W MAIN STREET BOX 879 YADKINVILLE, NC 27055

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F 356	Continued From page 11 the data needed to include the total number of hours worked, that it needed to be posted at the beginning of each shift or that the data needed to be revised when staff changes occurred. An interview with the director of nurses on 10/22/15 at 3:00 PM confirmed that the nurse staffing data is posted each morning for all 3 shifts, does not include the total number of hours worked for licensed and unlicensed nursing staff and it is not revised when staff changes occur. She further indicated that she was not aware that actual hours were required to be posted.	F 356	As evidence of compliance and as required by regulation, the daily postings shall be archived for no less than eighteen months. The Quality Assurance Committee shall review the daily postings for the most recent month following the recertification survey to ensure the postings are completed appropriately.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to check expiration dates of food stored in the walk in refrigerator and on the bread rack and remove the items by the expiration date. The findings included: Observations on 10/19/15 at 9:45 AM of the walk in refrigerator revealed a large container of chicken salad with an expiration date of 9/25/15 and two large containers of cottage cheese with	F 371	STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).	11/20/15

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F 371	Continued From page 12 expiration dates of 10/12/15. All three were available for serving to the residents. Observations of a bread rack revealed two bags of rolls that had expired 10/17/15. Interview with the dietary manager on 10/19/15 at 9:50 AM revealed the cook would be responsible for checking for expiration dates of stored foods. Her expectation would be for the checks to be done daily. She did not know why the foods had remained in the refrigerator and were expired. The bread man would be at the facility on 10/19/15 and would pick up the bread. Any expired bread should be placed on the bottom racks. The cook would be responsible for checking the bread as well. Review of the policy and procedure dated 1/7/15 for checking and disposing of out of date products indicated the cooks were to check expiration dates on all items prior to use. If any product was found to be out of date it is to be discarded immediately. Review of the policy for checking dates for bread and rolls dated 1/7/15 indicated before serving bread the cook was to check the expiration date. If found to be out of date it is to be put on the bottom shelf of the bread rack so the bread sales representative may discard unused products.	F 371	No residents were specifically identified as having been affected by this alleged deficient practice. For those residents having the potential to be affected by the same alleged deficient practice, the Dietary Manager shall inservice all dietary staff on the proper verification and management of food items noted to be expired. The Dietary Manager or designee shall monitor for compliance by completing an Expired Food Item Check daily for 2 weeks, weekly for 1 month and monthly thereafter to ensure no expired foods are used and/or served. The Dietary Manager shall report any findings monthly to the QA Committee for three months, then quarterly thereafter.	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and	F 456	STANDARD DISCLAIMER:	11/20/15

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F 456	Continued From page 13 staff interview the facility failed to ensure a hospital bed was operational for 1 of 1 sampled residents (Resident #60). The findings included: Resident #60 was admitted to the facility on 9/1/14 with a diagnoses that included right lower leg pain, peripheral vascular disease, and chronic obstructive pulmonary disease. The most recent minimum data set (MDS) assessment dated 7/31/15 indicated Resident #60 required total to extensive assistance with activities of daily living (ADL). The MDS further revealed Resident #60 was moderately cognitively impaired. Review of Resident #60 care plan revealed a " problem/need " of self-care deficit. The goal stated Resident #60 would have his needs met with staff intervention. The approaches included; provide total care for activities of daily living (ADL), bathe per schedule when hospice not providing them, ½ side rails up x 2 to assist with bed mobility, assist with feeding as needed, and coordinate ADL care with hospice on days hospice aide provide bathing and other ADL ' s as necessary. During an interview with Resident #60 on 10/20/15 at 1:45pm Resident #60 indicated his bed did not go up and down. Resident #60 revealed his bed had not had up and down function for about 3 months. Resident #60 stated someone had come in and looked at his bed and tried to fix it. Resident indicated no one had gotten back with him in regards to the up and down function of his bed. During an interview with Resident #60 family member on 10/20/15 at 1:45 pm revealed the facility was aware of his bed not properly functioning. She indicated that the bed had no up or down operation for about 4 or 5 months. She stated someone from maintenance had come in	F 456	The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). Resident #60□s has been replaced. For those residents having the potential to be affected by the same alleged deficient practice, the Maintenance Director has evaluated all the facility□s beds to ensure they are in proper working order. Any beds identified as not functional have been repaired and/or replaced. Evidence of such inspections shall be documented on the Bed Functionality Audit, which shall be incorporated into the facility□s preventative maintenance program. All beds shall be tested every 2 weeks for 1 month and then quarterly thereafter. All beds shall be inspected to ensure proper functioning by the Maintenance Director monthly to ensure proper functioning. All staff have received inservice education related to the facility□s established practice of completing work-orders for maintenance-related issues. The Quality Assurance Committee shall review the audit information monthly for 3 months and quarterly thereafter.	

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F 456	Continued From page 14	F 456		

to try to fix the bed but she heard nothing further about the bed.
Interview with the social worker on 10/21/15 at 9:51am revealed the facility filed complaints or grievances in the individual resident medical record. The social worker revealed in the instance staff had a concern they would call her and she would fill out the concern for them. No concern had been brought to the social workers attention in regards to Resident #60 ' s bed not operating up and down.
Record review for Resident #60 revealed no concerns in regards to his hospital bed not operating.
Interview with the Housekeeping Supervisor on 10/21/15 at 10:16 am revealed that in the instance anyone had a maintenance issue they would tell herself or the maintenance staff. Housekeeping indicated in the instance she could not correct the issue herself she would communicate the concern in writing to maintenance. She stated she would go back to maintenance the following week to identify if the maintenance concern was resolved. The Housekeeping Director indicated she had no concern reported to her in regards to Resident #60 bed not functioning properly. In the instance she was aware of the bed not working she would have replaced the bed and had the malfunctioning bed be put away for repair.
Interview with Maintenance staff on 10/21/15 at 10:20 am revealed he was made aware of maintenance needs by word of mouth and in writing communication by the Housekeeping Director. During observation of Resident #60 bed on 10/21/15, Maintenance indicated that he was unaware that Resident #60' s bed was not operating up and down.
Interview with Resident #60 Nurse #1 on 10/21/15

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F 456	Continued From page 15 at 10:46 am revealed she was not aware that Resident #60 bed did not go up or down. Nurse #1 stated that when she provided Resident #60 care, she had not had to raise the bed. She stated the residents bed head elevated and feet elevated. Interview with Nursing Assistant (NA) #1 on 10/21/15 at 10:50 am revealed Resident #60 required total assistance to complete activities of daily living. She further revealed that she had occasionally fed Resident #60. NA#1 stated that Resident #60 ' s bed started malfunctioning about a week ago. She stated that she had told a member of maintenance (name not known) that Resident #60 ' s bed was not operating up and down and the member of maintenance indicated they would check the bed out. NA#1 stated that there was no written communication system to notify maintenance of concerns. She only verbally communicated concerns to her nurse or directly to maintenance. Interview with hospice staff on 10/21/15 at 3:29 pm revealed she had made a nursing assistant (name unknown) aware of the hospital bed not going up or down when the remote was used. Resident #60 ' s bed had not had an up and down function for about 4 months. Interview with the Director of Nursing on 10/22/15 at 8:51 am revealed she was unaware of Resident #60 bed not operating. It was her expectation that resident beds function and staff communicate when resident beds are not operating correctly.	F 456		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system	F 463		11/20/15

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F 463	Continued From page 16 from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to ensure call lights were functioning at bedside and/or in bathrooms for three of forty sampled residents (Residents #103, 42 and 76). The findings included: Observations on 10/19/2015 at 2:20PM revealed the call light in the bathroom for Resident #76 would not activate when the chain was pulled. The light in the bathroom and outside the resident's door did not light up indicating the bathroom call light was activated. The bathroom was a shared between rooms 604 and 606 for four residents. Observations on 10/19/2015 at 2:35 PM revealed the call light in the bathroom of Resident #42 would not activate. The call light flickered but would not remain on and activated when the cord was pulled. The call light outside the resident's door did not light up indicating the bathroom call light was activated. Observations on 10/20/2015 at 1:28 PM revealed the call light at the bedside of Resident #103 was not functioning. When the call light was pressed, the light at the wall and outside the resident's door did not light up. Review of the call light checks by maintenance revealed checks were performed once a month.	F 463	STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). The call lights for Resident #□s 103, 42, and 76 have been repaired and are functioning properly. For those residents with the potential to be affected by the same alleged deficient practice, all call lights in the facility have been tested to ensure appropriate functioning. The testing of call lights has been documented by the Maintenance Director on the Call Light Test Audit. The audit records such information as follows: 1) call cord functionality (yes/no), 2) audible sound (yes/no), 3) visible display (yes/no). Such audits shall be done every two weeks for 1 month and monthly thereafter. In such an event that a call light is determined not to be functioning properly, the Maintenance Director shall repair the dysfunction. All staff have received inservice education related to the facility□s established practice of completing work-orders for maintenance-	

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F 463	Continued From page 17 The date of the last check was on 9/26/15. The audit (untitled) indicated all call lights in residents ' rooms and bathrooms had been checked. There were no issues with call lights identified on that date. A tour was conducted on 10/22/15 at 12:50 PM with the Director of Nursing, Housekeeping and Maintenance Directors. The rooms and bathrooms for Residents # 103, 42 and 76 were checked for call light functionality. Observations with the administration staff revealed the bathrooms for Residents #76 and #42 had call lights that were not functional. The call light at the bedside for Resident #103 did not activate. Interview with the Maintenance Director on 10/22/15 at 12:50 PM revealed he had not received information regarding call lights not working. He and housekeeping worked together with issues in rooms to be aware of what might be wrong. Interview with the Housekeeping Director revealed the housekeeping staff did not routinely check call lights. She was not aware the call lights were not working. Interview with the Director of Nursing revealed she would expect the staff to report call lights that were not working. If the call light was not working, the staff would have to yell for assistance in an emergency.	F 463	related issues, including issues related to poorly ill-functioning call lights. The Quality Assurance Committee shall review the audit information monthly for 3 months and quarterly thereafter.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		11/20/15

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F 514	Continued From page 18 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain accurate physician ' s orders on monthly recap orders for one of eighteen sampled residents. (Resident #66) The findings included: Resident #66 was admitted to the facility on 4/14/15 with diagnosis of hypertension, diabetes, and history of a stroke. The physician ' s orders dated 8/10/15 instructed nursing to increase Regular Novolin Insulin to 10 Units subcutaneous (sq) three times a day (TID) with meals. Review of the September and October monthly orders revealed the order was transcribed as Novolin R (regular) insulin sq TID " before meals. Hold if patient does not eat ... " The times of administration were at 7:30 AM, 11:30 AM and 4:30 PM. Interview with nurse #2 on 10/22/2015 at 8:54 AM revealed the order as transcribed on the MAR (Medication Administration Record) for the Novolin R insulin revealed it could not be provided as ordered. She would get a clarification of the order. The original order was reviewed with the nurse and she stated it read "with meals." Interview with nurse #1 on 10/22/15 at 9:20 AM revealed she administers the insulin to Resident	F 514	STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). The insulin order for Resident # 66 has been clarified and is currently administered pursuant to the attending physician□s order(s). For those residents having the potential to be affected by the alleged deficient practice, all resident□s current medication regimens have been reviewed to ensure the orders correspond to a previously written order. Evidence of such review shall be documented on the Medication Administration Record Audit. To ensure compliance, each residents□ medication regimen shall be reviewed monthly by two nurses independently in order to verify the accuracy of transcribed orders. Signatures affixed to the MAR□s shall be indicative of the review. Discrepancies	

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F 514	Continued From page 19 #66. Nurse #1 explained she usually made sure the resident ate her meal before giving the insulin. The resident had a history of " bottoming out " (having low blood sugar). If she did not eat at all, she would hold it. Interview with the Director of Nursing (DON) on 10/23/15 at 11:20 AM revealed the order was not accurate and should be clarified. The process for checking orders at the end of the month included one nurse who checked the orders with the new MARs. The DON explained that nurse should have caught the inaccurate order. The DON further explained she would complete a second check of the end of the month orders. Further interview revealed the DON could not say if she saw it (inaccurate order). Further explanation was provided indicating the nurses would not follow that order and it should have been clarified. A review in September for the second check had not been completed by the DON.	F 514	identified as a result of the monthly reviews shall be corrected. The count of errors identified from the monthly review shall be reviewed by the Quality Assurance Committee monthly for 1 month and quarterly thereafter.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		11/20/15

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F 520	Continued From page 20 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility ' s Quality Assessment and Assurance Committee (QA and A) failed to implement, monitor and revise as needed their plan developed for the recertification survey dated 12/04/2014, in order to achieve and sustain compliance. The facility had a repeat deficiency for housekeeping and maintenance services (F 253) on the current recertification survey of 12/04/2015. The continued failure of the facility during two federal survey of record showed a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. d: This F tag is cross referenced to: F 253: Based on observations, staff and resident interviews the facility failed to maintain the walls, tile floors, and shower chairs in a safe and sanitary manner in three of four shower rooms. The facility failed to maintain resident equipment in good condition in for five of eighteen sampled residents (Residents # 132, 90, 76, 103 and 133). The findings included: During the recertification survey of 12/04/2014, the facility failed to clean and repair heating/air condition systems for multiple rooms and provide	F 520	STANDARD DISCLAIMER: The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). The Plan(s) of Correction for F253 are incorporated herein by reference. To ensure compliance, each report identified in F253 shall be reviewed by the Quality Assurance Committee no less than monthly for 12 □ consecutive months. Subsequently, the facility shall re-evaluate the facility□s ability to ensure substantial compliance, specific to this identified deficient practice. In part, the facility shall evaluate the efficacy of the inspection and reporting regimen described herein at least quarterly. Such evaluations shall include a reconciliation	

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YADKIN NURSING CARE CENTER	903 W MAIN STREET BOX 879 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 520	Continued From page 21 light covers for all lights in two bathrooms. The facility failed to identify and repair broken and loose tiles on the walls and floors in two of three shower rooms, peeling paint on one wall of three shower rooms and two shower chairs with mesh seats in disrepair and covered with stains. One wheel chair scale being stored in shower room number three had rusting, peeling paint and the floor at the base of the scale had a rust stain ring around the scale base. An interview with the Director of Nurses (DON) on 10/23/2015 at 9:49 AM revealed that the QA and A committee met weekly to continue to review both new areas of concern as well as previous citations received until the committee determined that areas addressed were resolved. The DON stated that they had not discussed any new housekeeping or maintenance concerns at these meetings. The DON also revealed there was a continued weekly review of the air conditioner units, which had been replaced since the recertification survey dated 12/04/2014 but that the facility would need to bring new items to the committee meetings moving forward in order for the committee to meet its purpose to provide a safe and homelike environment for the residents. A review of the maintenance repair and audit logs from 12/2014 through 10/21/2015 confirmed that there were no new housekeeping or maintenance concerns being addressed by the QA and A Committee.	F 520	and verification of correction related to the items identified as needing to be remediated/corrected/repaired.	