STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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
E 000	Initial Comments An unannounced recertification and complaint investigation surveys were conducted on 11/14/23through 11/17/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #DQUM11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation surveys were conducted from 11/14/23 through 11/17/23. Event ID# DQUM11. The following intakes were investigated NC00208495, NC00208246, NC00207223, NC00204691, NC203486, NC003478, NC203056, NC00202986, NC00201531, and NC200423 NC00100881, NC00203138. 2 of the 32-complaint allegations resulted in deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	F 565		12/12/23

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

Electronically Signed | 12/12/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 565	Continued From page 1 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to resolve repeated concerns with scheduled smoking and diet preferences voiced during 2 of 5 months of consecutive Resident Council Meetings reviewed May 2023, thru October 2023. Findings included: The Resident Council Minutes for the period August 2023 through October 2023 were reviewed and revealed the following. The Resident Council minutes dated August 2023: * The staff did not take smokers out on schedule. * The preferences were not changed on the diet slips. The Resident Council minutes dated September	F 565	1. Per the 2567 the facility failed to resolve repeated concerns with scheduled smoking and diet preferences voice during 2 of 5 months of consecutive Resident Council Meetings. 2. All residents have the potential to be affected by the deficient practice if they are assessed to be a supervised smoker, with permission to smoke at facility designated times, and that have meals provided to them by the facility daily. The Activity Director held a smoking meeting with resident smokers on 12/12/23 to discuss compliance with smoking times. She discussed the process for supervised smokers, times and what to do if a staff member assigned does not come within 10 minutes of designated time. For example if the smoking time is 8:30 and no one has taken them out at 8:40 a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 565	Continued From page 2	F 565		

2023:

* Smoking issues regarding scheduled times and staff availability were not resolved.
* The dietary preferences were not resolved.

The Resident Council Minutes for October did not address any concerns or old business.

An interview on 11/15/23 at 11:40 AM with the interim Activity Director revealed that the previous Activity Director did not leave Resident Council minutes. She stated the resident council minutes were typed up from notes she found. She did not know if any if the grievances had been resolved or had a response.

A Resident Council meeting was conducted 11/17/23 at 10:40 AM the Resident Council President and 10 residents reported ongoing issues with smoking times and staff being available to take them out in the morning and evening. The group stated that the diet slips were incorrect. They were getting the same food every week. The group stated that the facility failed to respond and resolve any of the group's concerns. The Resident Council President revealed that old business was not discussed during the meetings. There was no resolution.

A review of the grievance logs for the period May 2023 through October 2023 revealed that there were no grievances filed on behalf of the Resident Council members' concerns regarding smoking schedules and dietary preferences.

Interview with Dietary Manager 11/17/23 at 2:30 PM revealed she had not been made aware of any concerns voiced by the Resident Council

resident will notify the 100 hall Nurse and she will take them out immediately. This will be reported by the 100 Hall Nurse to the Director of Nursing for corrective action with the assigned smoke aide. For residents who are safe smokers, they will let the Nurse on their unit know they are going out to smoke, Nurse will sign out a lighter for them and let them out to the smoking area. When they are ready to return they will ring the doorbell to come in and lighter will be returned to smoking box by Nurse, who will sign it back in. This will occur whenever they choose to go out to smoke. Every resident in the facility was interviewed by their respective Ambassador to update preferences of food and meals. Every updated preference was given to the Dietary Manager to enter into the Dietary System for preferences so that these preferences will show up on each residents dietary tray ticket. No adverse outcomes noted with this audit.

3. Education was provided to all Nursing Staff by the Administrator or Designee on 12/12/23 regarding the expectation for following designated supervised smoking times, assisting the unsupervised smokers and accurately assessing and communicating diet preferences to the Dietary Manager. The Dietary Manager and Activity Director received immediate education on 11/17/23. The Administrator or designee will monitor all residents that are supervised smokers, that they are able to go to smoke at the designated supervised smoking times. Unsupervised

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 565	Continued From page 3 about food preferences. Interview with the Administrator on 11/17/23 at 2:40 PM revealed that the Central Supply clerk had been the interim the Activity Director resigned abruptly in October. She further indicated the previous Activity Director did not communicate with specific departments related to the Resident Council. grievances. She stated that she knew there were concerns with the smoking times. She had the staff inform the smokers that they had to follow the designated times and could not go out earlier.	F 565	smokers will be interviewed 3x a week to ensure they are given a lighter and assist in and out of the smoking area whenever they choose to smoke. The Dietary Manager will be made aware of any diet preferences that resulted from a Resident Council Meeting within 24 hours of the council meeting each month. Any adverse outcome will be corrected immediately. 4. To ensure ongoing compliance, the Administrator and/or designee will conduct compliance audits 3 x a week for 12 weeks to ensure staff are taking supervised smokers outside at designated times, that unsupervised smokers are going out when they choose to and any diet preference that is verbalized by a resident via the Resident Council Meeting is brought to the Dietary Managers attention promptly and documented on their tray ticket.. The facility will provide education on any areas of concern noted. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved X 3 months.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		11/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 761	Continued From page 4 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to remove an expired multi-dose vials of insulin or put the date of opening on multi-dose containers of insulin and inhalers in the medication cart drawer for 2 of 7 medication administration carts (100 hall and 400 hall). Findings Included: 1.On 11/14/23 at 10:00 AM, an observation of the medication administration cart on 100 hall with Nurse #5, revealed one opened and undated Novolog insulin pen injector. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening; one multi-dose vial of Lantus insulin opened on 9/25/23. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28	F 761	1. Per the 2567, based on observation, record review and staff interview, the facility failed to remove an expired multi-dose vial of insulin or put the date of opening on multi-dose containers of insulin and inhalers in the medication cart drawer for 2 of 7 medication administration carts (100 hall and 400 hall). Items within this citation were corrected immediately. No adverse outcomes were identified. 2. All residents receiving insulin and inhaled medications have the potential to be affected by the deficient practice. In-service education via verbal and written format was provided by the Director of Nurse/designee beginning on 11/14/23 to all licensed Nurses and was completed on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 761	Continued From page 5 days after opening, which would be on 10/23/23; one Insulin Lispro multidose vial opened on 10/15/23. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening, which would be on 11/12/23. On 11/14/23 at 10:05 AM, during an interview, Nurse #5 indicated that the nurses, who worked on the medication carts, were responsible for discarding expired multi-dose vials. The nurse stated that she had not checked the date of opening or expiration dates on insulin vials in her medication administration cart at the beginning of her shift. The nurse did not administer expired insulin this shift. On 11/14/23 at 10:10 AM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible for checking all the medications in medication administration carts for the date of opening or expiration date and remove expired medications every shift. She expected that no expired items be left in the medication carts. 2.On 11/14/23 at 10:20 AM, an observation of the medication administration cart on 400 hall with, Nurse #6 revealed two opened and undated, multi-dose vial of Levemir insulin. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 42 days after opening; one multi-dose Aspart insulin pen injector, opened on 9/21/23. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening, which would be on 10/19/23; one multi-dose Lantus insulin pen injector, opened on 10/4/23. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening,	F 761	11/17/23 on proper policies and procedures related to medication storage/labeling and drug storage. A full house audit of all residents on insulin medication and inhalers was performed to ensure proper labeling and accurate dates were in place. This was conducted by the Director of Nursing/designee to ensure all Yanceyville Rehabilitation and Healthcare Center staff are appropriately following our medication label/storage and drug storage policies and procedures. No further deficient practice was noted. 3. Mandatory verbal and written all staff education on policies and procedures related to Medication storage/labeling and drug storage. Immediate education/intervention were provided to Nurse #5 and Nurse #6 on 11/14/23. Full house education was initiated on 11/14/23 and completed on 11/17/23. All new hires will have this mandatory education prior to working on the unit with written and verbal education format. Daily ongoing observation and education will be provided also to maintain compliance. 4. To ensure ongoing compliance, the Director of Nursing or designee will perform 3 X week audits on all shifts to ensure compliance with Medication storage/labeling and drug storage. The results of the Medication labeling and drug storage audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved X 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 761	Continued From page 6 which would be on 11/1/23; two opened and undated inhalation containers of Fluticasone Propionate and Advair Discus. A review of the manufacturer's literature indicated to discard the inhalers 30 days after removed from the foil pouch; one opened and undated inhalation container of Budesonide. A review of the manufacturer's literature indicated to discard the inhaler 3 months after removed from the foil pouch. On 11/14/23 at 10:25 AM, during an interview, Nurse #6 indicated that the nurses, who worked on the medication carts, were responsible for discarding expired multi-dose vials. The nurse stated that she had not checked the date of opening or expiration dates on insulin vials or inhalers in her medication administration cart at the beginning of her shift. The nurse did not administer expired insulin this shift. On 11/14/23 at 10:30 AM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible for checking all the medications in medication administration carts for the date of opening or expiration date and remove expired medications every shift. She expected that no expired items be left in the medication carts.	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;	F 803		12/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 803	Continued From page 7 §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews, the facility to follow the menu for 1 of 1 meal observations for 4 of 4 residents(Resident #7, #58, #109 and #49). During the lunch meal the facility ran out of chicken thighs. The findings included: Review of the facility's lunch meal menu and spreadsheet revealed residents were to receive rancher's chicken thigh, country style tomatoes, black-eyed peas, dinner roll and pumpkin pie and there was no alternate indicated on the menu or on the resident meal ticket on 11/16/23. The entire facility resident meal tickets all read the main meal with no alternate.	F 803	1. Per the 2567 the facility failed to serve all residents the lunch menu that was documented on each residents tray ticket. 2. All resident have the potential to be affected by the deficient practice, that have meals provided to them by the facility daily. Residents #58, 109, 49, were given an apology and have been given, in writing a process to choose from the main meal, alternate meal or items always available. All other residents have also been given the same options. Menu's are posted in the hallways of the facility so that residents can easily see what is on the menu daily and can notify Nursing staff of a change, if they don't want the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 803	Continued From page 8 Observation of the tray line was conducted on 11/16/23 at 11:40 AM- 12:48 PM, the cook, dietary manager and kitchen supervisor were present when the cook ran out of chicken for the residents who received a regular diet. The cook began to serve up an alternate meal of Quiche which was not listed on the facility menu or spreadsheet. The Dietary Manager and Kitchen Supervisor both stated the cook probably had not followed the menu correctly to ensure there was enough food per the recipe. There was no explanation offered by the dietary manager or kitchen supervisor why there was not enough chicken to serve all the residents. Review of the meal tickets there were 11 residents that did not receive the chicken thigh. An interview was conducted on 11/16/23 at 11:50 AM, the Kitchen Supervisor stated she was responsible for monthly kitchen inspections and her last visit was on 10/31/23. She indicated the dietary manager was responsible for checking behind the staff to make sure things were done and the cooks were following the corporate menus and ordering food/supplies weekly. Observation was conducted at 1:00 PM on 11/116/19 in the main dining room revealed several voiced concerns about the meal served was not on the menu. a.Resident #7 was admitted to the facility on 8/24/22. Review of Resident #7's quarterly Minimum Data Set (MDS) dated 10/3/23 revealed Resident #'7s ate independently and his cognition was intact. The November 2023 physician order revealed a carbohydrate-controlled, regular diet and thin liquids.	F 803	schedule main meal on the menu. Nursing staff will bring the change in meal preference to the kitchen prior to the start of service so that the resident's get their choice. 3. Education was provided to the Dietary Manager on 11/17/23 that tray tickets must reflect the meal served to the resident and any changes in the meal planned need to be communicated to Nursing Staff to provide residents with an alternate choice. Education was provided to all Dietary Staff by the Administrator on 12/7/23 regarding the expectation that tray tickets are followed, the meal served to each resident is the meal documented on the tray ticket and any changes to the menu are communicated to Nursing Staff so they can notify the residents of a change and give them a choice in an alternative. The Nursing and Dietary Staff were educated on the updated process for choices of residents with meals on 12/12/23. 4. To ensure ongoing compliance, the Administrator and/or designee will conduct compliance audits 3 times per week for 12 weeks to ensure tray tickets reflect the meal served. At least 10 tray tickets will be reviewed and the meal on the tray to ensure it is the meal on the ticket. The Administrator and/or designee will provide education on any areas of concern identified. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance is achieved for 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 803	Continued From page 9 An observation and interview were conducted on 11/16/23 at 1:15 PM, Resident was observed not eating what was served on the tray. Resident #7 stated he was looking forward to the chicken and he did not know why he got the eggs. Resident #7 further stated he was told by the aide the kitchen ran out of chicken. He indicated everyone gets the same food and the residents did not have a menu to select from. Everyone just eats what was served. b. Resident #58 was admitted to the facility on 8/1/23. Review of Resident #58's quarterly Minimum Data Set(MDS) dated 9/14/23, revealed Resident #58's cognition was moderately impaired with supervision during meals. The November 2023 physician order was heart healthy, regular diet and thin liquids with supervision during meals. An observation and interview were conducted on 11/16/23 at 1:16 PM, Resident #58 was observed only eating the dessert on the tray and not the other items on the tray. She stated she wanted the chicken and was not sure why she did not receive the chicken and she did not want eggs. c. Resident #109 was admitted to the facility on 2/20/23. Review of Resident #109's significant change Minimum Data Set(MDS) dated 9/30/23, revealed Resident #109 cognition was moderately impaired with supervision during meals. . The November 2023 physician order revealed a carbohydrate-controlled, regular diet and thin liquid. An observation and interview were conducted on 11/16/23 at 1:17 PM, Resident #109 was observed not eating the meal served. He stated	F 803	months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 803	Continued From page 10 he did not want breakfast for lunch and the board said chicken. Resident #109 further stated he asked the aide what happened with the chicken and was told they probably ran out of chicken, so he got the substitute. d. Resident #49 was admitted to the facility on 2/7/23. Review of Resident #49's significant change Minimum Data Set(MDS) dated 9/30/23, revealed Resident #109 cognition was moderately impaired with supervision during meals. The November 2023 physician order revealed a no added salt regular texture diet and thin liquids. An observation and interview were conducted on 11/16/23 at 1:18 PM, Resident #49 stated he was looking forward to the chicken and the aide told him they were out of chicken. Resident #49 stated the residents never knew what the meal choice were because everyone was getting the same food even if we they did not like it. They seem to run out of food so often. He reported he ate what was given. An interview was conducted on 11/17/22 at 7:30 AM, the Administrator stated the Dietary Manager and Kitchen Supervisor was responsible for ensuring there was enough food in accordance with the menus, physician orders and resident diets.	F 803		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;	F 806		12/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 806	Continued From page 11 §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to obtain and honor food likes/dislikes and to provide an alternative meal of similar nutritive value for 4 of 5 sampled residents, (Resident #88). Findings included: Resident #88 was admitted to the facility on 11/22/22 with diagnoses of Diabetes Mellitus, and Gastroesophageal reflux disease. A review of the most recent Minimum Data Set dated 08/20/23 revealed Resident #88 was cognitively intact and fed himself after he was set-up. A review of the Care Plan for Resident #88 dated 8/23/23 goal was to maintain nutrition and weight without significant change. The interventions were to honor food preferences, provide the diet as ordered and report weight loss/gain to the doctor. A review of the orders revealed 11/20/22 Resident #88 was on a diabetic diet. A review of the weight log revealed a 7lb. weight loss was recorded between the months of February 2023 and September 2023. A review of the Food Preferences Form for	F 806	1. Per the 2567, the facility failed to obtain and honor food likes/dislikes and to provide an alternative meal of similar nutritive value. 2. All residents have the potential to be affected by the deficient practice that have meals provided to them by the facility daily. No adverse outcomes noted during this audit. Resident #88 was visited by his Ambassador on 12/12/23/and had likes/dislikes updated. Preferences were given to the Dietary Manager for input into the Dietary System so preferences will be shown on all tray tickets. All other residents were also visited by their respective Ambassador, preferences were recorded for each of them and given to the Dietary Manager for input into the Dietary System so preferences will be shown on their tray tickets. 3. Education was provided to the Dietary Staff by the Administrator on 12/7/23 regarding tray tickets, likes and dislikes, alternate meals and always available items for residents. This process will be completed by 12/12/23. The Administrator met with representatives of the Resident Council on 12/7/23 to discuss survey findings, kitchen issues and explain process changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 806	Continued From page 12 Resident #88 dated 11/22/22 completed on admission indicated no food preferences. A review of the lunch card for Resident #88 dated 11/14/23 revealed no likes or dislikes. An Interview conducted on 11/14/23 at 10:55 AM with Resident #88 indicated he received macaroni and cheese on his dinner tray, which he disliked cheese. He had asked the Nurse aide to bring something else and heat up his food, but the Nurse aide did not honor either request. He stated he spoke with the Dietary Manager occasionally regarding his food choices, and he continued to receive cheese on his tray. He also revealed that he was not aware of any other food items that were available as an alternative, because they were never offered. An Interview with the Dietary Manager, on 11/14/23 at 1:16 PM, revealed she had not talked with Resident #88 about his food preferences on admission and had not followed up to obtain preferences. The Dietary Manager indicated that she or the dietician interviewed the residents upon admission and recorded food preferences. She further indicated that she had not followed up because she had to work a lot in the kitchen. She then revealed at one time the residents received an alternate menu, but that had not continued. An Interview with Nurse #8 on 11/15/23 at 10:30 AM revealed that Resident #88 frequently complained he disliked the food on his tray. She had heard him tell the Nurse aide he wanted something else during lunch tray pass. She stated that the kitchen did not offer alternate meals or choices for residents. Observation of the breakfast meal card for	F 806	4. To ensure ongoing compliance, the Administrator and/or designee will conduct compliance audits for 10 random residents 3 times per week for 12 weeks to ensure likes/dislikes are followed, alternates are offered and available when needed. Resident Council concerns will also be addressed after each meeting by the Dietary Manager. The Administrator and Dietary Manager will provide education and follow-up on any areas of concern identified. The results of the audits will be reported at the monthly QAPI Meeting until such time that substantial compliance is achieved for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 806	Continued From page 13	F 806		

Resident #88 dated 11/16/23 revealed no likes or dislikes listed.
An Interview with Nurse Aide #6 on 11/16/23 at 2:30 PM indicated that she was not aware of a second meal choice or alternative she could offer to residents.

Interview with Nurse Aide # 4 on 11/17/23 at 12:10 PM There was a small menu on the dining room wall near the kitchen, that showed what the meals of the day were. She further revealed she was not aware of the alternate meal or if other options were available.

Interview with Director of Nursing (DON) on 11/16/23 at 3:00 PM revealed her expectation of the dietary department was to follow diet orders and provide nutritious meals for the residents with alternatives for dislikes. She further indicated that the resident's food preferences were obtained during the admission process by the dietary manager and followed up on the Care Plan. She further revealed the facility did not have a dietician in place until recently to follow up on this task.

On continuous observation during the breakfast meal of a resident in the dining room, on 11/17/23 at 8:20 AM, a Nurse Aide went to the kitchen door to obtain an order of grits instead of cold cereal for this resident. The Nurse aide returned to the table and stated there were no grits. No other option was offered.

An Interview was conducted with the Administrator on 11/17/23 at 3:45 PM, she stated she was aware of the poor service from the contracted kitchen staff failing to provide alternate meals for the residents. The contracted staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 806	Continued From page 14 failed to order enough food to have alternates. She had previously requested from the corporation a discontinuation of the contracted services. She has not received an answer.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep food preparation areas, food storage areas and food service equipment clean, free from debris, grease buildup, and/or dried spills on the floor during two kitchen observations. The facility failed to clean the ceiling vents and air condition units located over the food prep and food service area. This practice had the potential to affect food served to all residents.	F 812	1. Per the 2567 the facility failed to keep food preparation areas, food storage areas and food service equipment clean, free from debris, grease buildup and/or dried spills on the floor, failed to clean ceiling vents and air conditioning unit. 2. All residents have the potential to be affected by the deficient practice if they have meals provided to them by the	12/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 812	Continued From page 15 The findings included: 1.During a kitchen tour on 11/14/23 at 10:00AM, the following observations were made with the dietary manager: a. The 6- stove burners had heavy grease build-up on the stove burners, walls behind the stove, and front of the stove. There were large amounts of burnt foods, dried, encrusted, liquid and splatters throughout the stove area. The inside and outside of the combination stove and oven doors had grease buildup, dried foods, and liquid spills. b. The 4-compartment ovens had a heavy grease buildup, dried food, and liquids on the inside and outside. The grease buildup was encrusted on doors/shelves where food was being cooked. There was a dried grease buildup observed on the fronts of the ovens and on the walls on the inner walls of the oven or on the walls behind the oven. c. The 5 compartment steam tables had large volumes of leftover food in standing water. Under the steam table there were 9 clean steam table lids stored on dirty surfaces where foods crumbs d. The 8 ceiling vents and 1 air conditioner had large volumes of black dust/debris blowing over food service and prep surfaces and clean dishes area. e. The 3 -compartment plate warmer had 3 rows of clean plates stored in the warmer. The inside of warmer had dried liquid spills and food particles inside and dried liquid spills on the outside. The inside also had old food crumbs all around.	F 812	facility daily. The Administrator met with the Resident Council on 12/7/23 to review survey findings, discuss issues in the kitchen and process changes to correct these issues. Administrator assured the Resident Council that the kitchen was clean on 11/17/23 and will remain clean through a series of regular audits completed by the Regional Dietary Manager and the Administrator. 3. All surfaces, equipment, vents, floors were cleaned on 11/17/23 by Dietary Staff. Retraining for all staff was provided by the Dietary Manager and/or Regional Dietary Manager on 11/17/23 - 11/20/23 and will be ongoing as new staff are hired. Education was also provided to all Dietary Staff on 12/7/23 by the Administrator regarding maintaining a clean sanitary kitchen at all times and expectations for all Dietary Staff. 4. To ensure ongoing compliance, the Administrator and/or Regional Dietary Manager will conduct compliance audits 3 times per week for 12 weeks to ensure the kitchen equipment, surfaces, floors, vents are clean and sanitary. The Dietary Manager will provide education on any areas of concern noted. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has bee achieved X 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 812	Continued From page 16	F 812		

f. The floor underneath the stove, fryer, steamer, and ovens had large amounts of dried food, grease puddles and paper products.

An interview was conducted on 11/14/23 at 10:15 AM, the Dietary Manager stated staff were required to wipe down all kitchen equipment and floors after each meal and deep clean the equipment weekly. The Dietary Manager acknowledged the identified kitchen equipment, ceiling fan and air condition units had not been cleaned in several months. The DM state staff were expected to sign off the task was clean according to the checklist. The Dietary Manager stated the maintenance staff were responsible for cleaning the ceiling vents.

A follow-up observation conducted was done with the Dietary Manager (DM) and Kitchen Supervisor on 11/16/23 at 11:14 AM, of the identified kitchen equipment and concerns. The equipment remained the same as on the initial tour on 11/14/23. Some areas have been worked on but not yet complete. The Kitchen Supervisor further stated she was responsible for ensuring the kitchen staff kept the equipment clean and orderly during her monthly inspections. All staff were responsible for ensuring kitchen equipment was wiped down daily and cleaned weekly in accordance with the kitchen cleaning checklist. The maintenance staff was responsible for cleaning ceiling vents/fans.

An interview was conducted on 11/17/22 at 7:30 AM, the Administrator stated the Dietary Manager and Kitchen Supervisor was responsible for ensuring the kitchen was cleaned and maintained. The expectation would be for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 812	Continued From page 17 Dietary Manager to ensure all kitchen cleaning protocols were in place and followed in accordance with kitchen sanitation guidelines. The Administrator stated the kitchen staff were responsible for ensuring the venting system was clean in the kitchen. An interview was conducted on 11/17/23 at 1:10 PM, the Maintenance Director stated maintenance staff was responsible for changing the filters, the kitchen staff responsible for keeping the vents clean.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance	F 867		12/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 867	Continued From page 18	F 867		

indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 867	Continued From page 19 §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 867	Continued From page 20 (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review of the Facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 12/14/21 annual recertification survey. This was for one recited deficiency in the areas of dietary services (F 812). This deficiency was cited again on the annual recertification survey on 11/17/23. This continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross referenced to: F- 812 Based on observation, interviews, and record review the facility failed to label and date food and failed to maintain the nourishment refrigerator clean for 2 of 2 nourishment refrigerators reviewed for food storage (nourishment refrigerator #1 on 200 hallway and nourishment refrigerator #2 on 600 hallway). During the recertification survey, the facility was cited for F812 the facility failed to keep food	F 867	1. Per the 2567, based on staff interview and record review, the Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee put into place following the 12/14/21 annual recertification survey. This was for one recited deficiency in the area of Dietary Services (F812). This deficiency was cited again on the annual recertification survey on 11/27/23. This continued failure to the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. No adverse outcomes were identified. 2. All residents receiving dietary meals from the kitchen have the potential to be affected by the deficient practice cited in F812. The VP of Operations has provided 1:1 education with the Administrator on 11/17/23. Education was provided by the Regional Manager of Dietary Services beginning on 11/17/23 and will be completed by 12/11/23 on proper policies and procedures related to labeling, dating food items and proper cleanliness in food preparation areas, kitchen to be free from	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 867	Continued From page 21 preparation areas, food storage areas and food service equipment clean, free from debris, grease buildup, and/or dried spills on the floor during two kitchen observations. The facility failed to clean the ceiling vents and air condition units located over the food prep and food service area. This practice had the potential to affect food served to all residents. During an interview with the Administrator on 11/17/23 at 4:52 PM the Administrator indicated kitchen issues were a problem.	F 867	debris, grease build up, cleaning of ceiling vents and AC unit located over food prep/food service area and proper sanitization of dried spills on floors. A full audit of these areas in the kitchen was performed on 12/7/23 by the Regional Dietary Manager, Dietary Manager and Administrator to ensure all Yanceyville Rehabilitation & Healthcare Center kitchen staff are appropriately adhering to safe and effective cleaning practices and storage and labeling procedures in the kitchen area. Any areas identified were corrected immediately. 3. All Dietary staff completed mandatory education on policies and procedures related to safe and effective labeling/storage and cleaning practices within the kitchen environment. This was completed on 12/7/23. Immediate education/intervention was provided to the Dietary Manager on 11/17/23 by the Administrator. All new Dietary employees will have this mandatory education prior to working in the kitchen. Daily ongoing observation and education will be provided also to maintain compliance. The District Director for HSG and/or Designee will attend the facilities QAPI Monthly meetings to ensure compliance. 4. To ensure ongoing compliance, the District Director for HSG and/or Designee will attend facilities monthly QAPI meeting and monitor the results from the Dietary cleanliness audits. They will also provide education on any areas of concern. The results of the audits will be reported at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YANCEYVILLE REHABILITATION AND HEALTHCARE CENTER	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 867	Continued From page 22	F 867	monthly QAPI meeting until such time that substantial compliance has been achieved X3 months.	