STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345167	A. BUILDING _____ B. WING _____	07/16/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0676 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, the facility failed to implement restorative services as referred by the facility's rehabilitative department to maintain or improve a resident's level to ambulate and transfer for 1 of 2 sampled residents reviewed for restorative services (Resident #12). Findings included: Resident #12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The review of the Care Plan dated 2/18/20, revealed Resident #12 had an activities of daily living (ADL) self-care performance deficit related to confusion, impaired balance, limited mobility, limited range of motion (ROM), pain and right wrist fracture. Interventions included: refer to physical and occupational therapies, whenever necessary; praise all efforts at self-care; and allow the resident plenty of time to complete tasks. The quarterly minimum (MDS) data set [DATE] indicated Resident #12 was severely cognitively impaired; required limited assistance with bed mobility, transfers, toileting, walking, and hygiene; had no impairments with range of motion. The resident's Physical Therapy Discharge Summary dated 6/17/20 recommended Resident #12 continue ambulation and exercise with the facility's Restorative Program. There were two Restorative Care Referrals dated 6/17/20 indicating Resident #12 was to receive: the ROM and walking restorative services 6-times per week and contact guard for walking; and the walking and transfers restorative services 1-time per day, 5-times per week with contact guard and minimal assist. Instructions were provided to the restorative aides. Both referrals indicated these services were to begin on 6/18/20. There was no documentation available in the resident's medical record that specified Resident #12 received restorative services from 06/18/20 to 7/13/20. During an interview on 7/13/20 at 3:41 p.m., the Occupational Therapist (OT) stated that Resident #12 was currently receiving OT which was restarted on 5/19/20 due to her decline in self-care and would be discharged from OT on 7/14/20. The OT stated the resident received PT (physical therapy) for ambulation and was discharged on [DATE]. The OT revealed that whenever a long-term care resident completed and was discharged from therapy, the resident was referred to the facility's Restorative Program for maintenance. During an interview on 7/14/20 at 2:55 p.m., Restorative Aide (RA) #1 stated Resident #12 was currently not receiving restorative services as requested by PT on 6/17/20, because the resident continued OT. She explained that if a resident received therapy from multiple disciplines (OT, PT, ST) and was discharged from one of the therapies with a referral for restorative, the resident would not receive restorative services until the resident was discharged from all of the therapy disciplines. On 7/14/20 at 3:00 p.m. during an interview, the Administrator stated the Minimum Data Set (MDS) Coordinator oversaw the facility's Restorative Program but was not available for interview. The Administrator stated that once the rehabilitative department submitted a referral for a resident to receive restorative, her expectation was for the restorative services to begin in a timely manner. During an interview on 7/14/20 at 3:28 p.m., the Rehabilitative Manager and the facility's OT revealed the restorative referrals were discipline specific (OT, PT, or ST). Resident #12 was weightbearing as tolerated. The resident's orthopedic follow-up visit would not have delayed or impacted her start date for restorative services. During an observation on 7/14/20 at 4:00 p.m., Resident #12 was propelling herself in her wheelchair towards the nursing station from her room. The resident was verbally responsive, but with hearing difficulties. During a telephone interview on 7/15/20 at 4:33 p.m., the Administrator revealed the Director of Nursing (DON) was able to locate documentation which showed Resident #12, only received restorative services for two days (on 6/18/20 and 6/19/20). She stated that both restorative aides were re-educated on the expectation that restorative referrals were to be started with residents when referrals were recommended by the rehabilitative discipline to ensure continuity of the program as planned when discharged from therapy. During a telephone interview on 7/16/20 at 12:09 p.m., the Rehabilitative Manager stated that if a resident did not receive restorative services when and as requested by the rehabilitative department, the resident could possibly loose his/her quality and consistent distance of ambulation.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews and wound physician interview, the facility failed to provide pressure ulcer care per physician orders, assess and monitor a resident's buttocks pressure ulcer, and ensure the resident's heels were floated off the bed to relieve pressure for 2 of 5 (Resident #7 & Resident #18) sampled residents reviewed for pressure ulcers. Findings included: 1. Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had cognitive deficit and required one-to-two-person extensive assistance with bed mobility, transfers and toileting. Resident #7 was non-ambulatory and incontinent of bowel and bladder. The MDS documented that Resident #7 was at risk for pressure ulcers and had acquired one stage 4 pressure ulcer and two unstageable pressure ulcers during her admission to the facility. The resident's care plan, which was updated on 6/26/20, specified Resident #7 had skin breakdown, was at risk for pressure ulcer development related to decreased mobility, incontinence, poor appetite due to poor prognosis related to my terminal illness. Care plan interventions included frequent position changes, incontinence care as needed, and staff to encourage more meal/supplement intake. A review of the physician's orders [REDACTED].#7's stage 4 sacral wound with normal saline, apply calcium alginate, Santyl, and to cover with dry dressing daily. There was also an order [REDACTED]. Review of the medication and treatment administration records from June 2020, revealed that staff had documented that they were completing both of the treatments ordered for Resident #7 at 2:00 PM daily. During a dressing observation with Nurse #3 on 7/12/20 at 1:00 PM, the dressing Nurse #3 was observed to place on Resident #7's sacral wound was a dry dressing with dakins packed into the wound bed. Nurse #3 stated that she had cleansed the wound, applied Santyl and then had packed the wound with dakins wet to moist dressing. There was no calcium alginate applied to wound bed. When asked if she usually does the treatments, she stated that there is no treatment nurse, so depending on the assignment, she does them on occasion. During an interview and review of the treatment orders on 7/13/20 at 10:50 AM with Nurse #3 there were several orders in place for the stage 4 sacral dressing. When asked to verify what she had applied to the resident's wound on 7/12/20 she stated again that she had cleansed the wound, applied Santyl with crushed [MEDICATION NAME], packed with dakins, and covered with a dry dressing, there was no calcium alginate placed during the dressing change. During an interview with the Unit Manager on 7/13/20 at 11:18 PM she stated that orders from the Wound MD were transcribed and double checked by her. When shown the multiple orders for Resident #7's dressing changes, she stated that the old treatment orders must not have been discontinued. The Unit Manager called the Wound MD and verified the correct orders that he wanted for her treatment. A new order was placed on 7/13/20 to clean Resident #7's stage 4 sacral wound with normal saline, apply calcium alginate, Santyl with crushed [MEDICATION NAME] to wound bed and to cover with dry dressing daily. When asked if it was possible to perform both of the dressings ordered at 2:00 PM as documented, she stated no it was not. During an interview with the

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

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Wound MD on 7/14/20 at 2:03 PM he stated that he was notified of the multiple dressings ordered and had specified to staff that he wanted Resident #7's stage 4 sacral wound cleansed with normal saline, to apply calcium alginate, Santyl with crushed [MEDICATION NAME] to wound bed and to cover with dry dressing daily. He stated that the dakins solution counteracts the Santyl [MEDICATION NAME] agent. When asked if this could have harmed the resident, he stated that it would not harm the resident, and added that it was his expectation that his wound treatment orders were followed and deleted when new ones were added. 2. Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A record review revealed Resident #18 had a pressure ulcer risk assessment completed on 5/22/20. The resident's total score was 17, indicating she was at risk for pressure ulcer development. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had intact cognition. She required extensive assistance of 2 people with bed mobility, transfers and toileting. Resident #18 was non-ambulatory and continent of bowel and bladder. She had no current pressure ulcers and was at risk for developing pressure ulcers. The resident's care plan, which was updated on 6/15/20, specified Resident #18 had a pressure ulcer on her buttocks and was at risk for pressure ulcer development related to decreased ability to assist with repositioning. Care plan interventions included frequent position changes, encourage weight shifting and float heels on pillow when in bed. A review of the physician's order [REDACTED]. Resident #18's medical record revealed from 6/17/20 to 6/24/20 there was no information documented in the medical record regarding the condition of the pressure ulcer on the resident's buttocks. A progress note dated 6/25/20 by the physician revealed Resident #18 had developed a small open wound to her right inner buttock approximately 5 centimeters by 5 centimeters with no surrounding [DIAGNOSES REDACTED] and non-draining granulation base. Resident #18's medical record revealed from 6/26/20 to 7/14/20 there was no information documented in the medical record regarding the condition of the pressure ulcer on the resident's buttocks. An observation on 7/14/20 at 8:20 AM revealed Resident #18 was lying in her bed. Resident #18's feet and heels were resting flat on the mattress; her heels were not floated on a pillow as specified in her care plan. An observation of wound care on 7/14/20 at 9:15 AM revealed Resident #18 lying in her bed with her feel and heels lying flat on the mattress; her heels were not floated. Observation was made of a small open area approximately pea-sized on Resident #18's right buttock. Nurse #1 completed the treatment per the physician's orders [REDACTED].#1 on 7/14/20 at 9:15 AM. She stated the facility did not have a wound care nurse. She stated the nurses did their own treatments unless there was an extra nurse on staff that could perform the resident's treatments. She stated when she did the treatments, she signed off on the TAR. She stated she did not measure Resident #18's pressure ulcer and she was not being seen by wound care. Nurse #1 was unaware of who was responsible for measuring the residents pressure ulcer. She stated the Director of Nursing would have to be asked for information regarding measuring and weekly documentation of the resident's pressure ulcer because she did not know. An interview was conducted on 7/14/20 at 1:50 PM with Nurse Aide (NA) #1. NA #1 stated she knew Resident #1 had to have her heels floated because she tried to float all of the resident's heels. The surveyor asked NA #1 why Resident #18's heels were not floated while she was in bed during the morning of 7/14/20 NA #1 replied, second shift puts her in bed. An interview was conducted with the Director of Nursing (DON) on 7/14/20 at approximately 3:30 PM. She stated information on wounds was in the resident charts. The surveyor requested the DON to provide information on Resident #18's pressure ulcer that was on the resident's buttocks. An interview was conducted with the DON and the Administrator on 7/15/20 at 8:28 AM. The Administrator stated they did not currently have a wound care nurse and she was aware there were concerns regarding wounds not being tracked. Email correspondence from the Administrator to the surveyor on 7/16/20 at 6:16 PM indicated the facility was unable to find any documentation of assessment or evaluation of Resident #18's buttocks pressure ulcer from 6/17/20 to 6/24/20 and from 6/26/20 to 7/14/20.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observations, staff interviews and review of the facility's Policy titled, COVID-19 Preparation and Response, the facility failed to implement their COVID-19 policy on wearing required personal protective equipment (PPE) when 1 of 1 staff failed to wear a mask that covered her mouth and/or nose while working at an opened nursing station (Nurse #2). This failure occurred during a COVID-19 pandemic. The findings included: A Review was conducted of the facility policy Titled, COVID-19 Preparation and Response, revised on 6/26/2020. The policy specified that all employees will wear a mask while in the facility with the only exception when in an office alone and while eating. On 7/14/2020 at 10:16 a.m., Nurse #2 was observed sitting at a nursing station, that was open to the hallway, wearing a mask that was positioned below her nose. During an interview with Nurse #2 on 7/14/20 10:17 a.m., she stated her mask was too loose and slid down. The Nurse was repositioned the mask to cover her nose. On 7/14/2020 12:32 p.m. to 12:34 p.m., Nurse #2 was observed sitting at the nursing station not wearing a mask with her nose and mouth uncovered On 7/14/2020 at 2:02 p.m., Nurse #2 was observed sitting at the nursing station with her mask positioned below her nose. Her nose was completely uncovered. On 7/14/2020 at 3:15 p.m., Nurse #2 was observed sitting at the nursing station with a mask properly positioned on her nose and face. At this time, an interview was conducted with the Nurse #2. She stated that infection control education was completed on the COVID-19 signs and symptoms to assess for in staff and residents. She stated that staff were educated on when to wear personal protective equipment such as gowns, mask, gloves and how to appropriately put on each item and remove the item. They were checked off by the infection control nurse on proper use. She stated that staff were trained on the COVID-19 facility policy and provided a copy to review. On 7/15/2020 at 1:24 p.m., a telephone interview was conducted with the Administrator. The Administrator stated that it was her expectation that all staff wear a mask in the facility in resident care areas, hallways and areas open to residents. She stated staff should only remove their mask if they were in an office alone.