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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yadkin Nursing and 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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, the facility failed to maintain a clean and homelike environment in 3 of 21 resident rooms on 1 of 3 halls (100 hall) reviewed for a safe, comfortable, and homelike environment (Resident #9, Resident #21, Resident #28, Resident #69, and Resident # 72). The findings included: An observation of Resident #9's room on 03/02/26 at 1:01PM revealed a large area on the floor on the right side of the bed covered with a black residue that was able to be removed. A napkin, dental floss pick, and an empty medication cup were observed under bed. Crumbs and a heavy layer of dust were observed on the floor under the head of the bed, and on the top left side and under the base of the Packaged Terminal Conditioner (PTAC). A used glove was noted on the floor in front corner of room. The overbed tabletop was covered with sticky residue and the base of the table was covered with a raised, white residue. Resident #9 did not have a roommate. On 03/03/26 at 4:06PM an observation of Resident #9's room revealed a large area on the floor on the right side of the bed covered with a black residue. A napkin, dental floss pick, and an empty medication cup were observed under bed. Crumbs and a heavy layer of dust were observed on the floor at the head of the bed, and on the left side of the top and under the base of the PTAC unit. A used glove was noted on the floor in front corner of room. The overbed tabletop was covered with sticky residue and the base of the table was covered with a raised, white residue. The trashcan in the room had no liner but was full of trash. A pink, raised residue was observed on 2/3 sides of the trashcan. An observation of Resident #21 and Resident #69's room on 03/02/26 at 1:21PM revealed a heavy layer of dirt and dust behind Bed B. Food, paper particles, pieces of an artificial flower, and a thick layer of dust and dirt were observed on the floor under the PTAC unit. There was a thick layer of dust on the top and bottom surfaces of the baseboard throughout the room. In the bathroom behind the toilet a wallpaper patch that did not match the rest of the wallpaper was observed; the patch was stapled in place. On 03/03/26 at 4:15PM an observation of Resident #21 and Resident #69's room revealed a heavy layer of dirt and dust behind Bed B. Food, paper particles, pieces of an artificial flower, and a thick layer of dust and dirt were observed on the floor under the PTAC unit. There was a thick layer of dust on the top and bottom surfaces of the baseboard throughout the room. In the bathroom behind the toilet a wallpaper patch that did not match the rest of the wallpaper was observed; the patch was stapled in place. An observation of Resident #28 and Resident #72's room on 3/2/26 at 3:09 PM revealed a trash can without a liner. Used gloves and food particles were observed on the bottom of the trashcan. Thick splatters of a pink dried material were observed on the sides and base of the trash can. In the bathroom, an approximately 6-inch piece of wallpaper under the sink had been cut and held in place with 2 thumbtacks. On 3/3/26 at 4:09 PM an observation of Resident #28 and Resident #72's room revealed a trash can without a liner. Used gloves and food particles were observed on the bottom of the trashcan. Thick splatters of a pink dried material were observed on the sides and base of the trash can. In the bathroom, an approximately 6-inch area of the wallpaper under the sink had been cut and was observed to be held in place with 2 thumbtacks. An interview was conducted with Housekeeper #1 on 3/3/26 at 3:43PM. She stated that her shift was 8:00AM to 4:00PM and she had been assigned to the 100 hall on 3/2/26 and 3/3/26. She stated her daily (continued on next page)

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

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

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NAME OF PROVIDER OR SUPPLIER Yadkin Nursing and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 903 W Main Street Yadkinville, NC 27055	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	responsibilities for each room on the hall included pulling trash from rooms and replacing the liner, cleaning the bathroom floor, sink, toilet, and mirror, dusting blinds, sweeping and mopping the room. She stated that floor cleaning included sweeping and mopping under the beds, pulling out and cleaning behind dressers and under the window units. She further stated she had completed the daily cleaning for Resident #9, Resident #21, and Resident #69's rooms on 3/2/26 and 3/3/26. An interview and observations of Resident #9, Resident #21/Resident #69 and Resident #28/Resident #72's rooms were conducted with the Director of Housekeeping on 3/3/26 PM from 4:43PM to 4:45PM. She stated that daily responsibilities for housekeepers included removing trash from each room and replacing the liner, cleaning the overbed tables tops and legs, cleaning the toilet, sink, and mirror, wiping the nightstands if needed, sweeping under each bed, and mopping from the window to door. The Director of Housekeeping stated that she conducts monthly inspections of every room using an audit sheet. She further stated if substandard work was observed, the assigned housekeeper must redo the room and training is provided. She stated housekeepers were trained to observe for potential needed room repairs and report to her. During her observation of Resident #9, Resident #21/Resident #69, Resident #28/Resident #72's rooms the Director of Housekeeping stated she stated the room cleanliness did not meet the standards of facility and she was embarrassed. An interview was conducted with the Maintenance Director on 3/4/26 at 3:31PM. He stated work orders were given to him through paper submission or staff approaching him on the unit. He stated that he did not conduct a routine inspection of each room to identify issues or to follow up on work completion by staff in his department. An observation of Resident #28/Resident #72's room was conducted with the Maintenance Director on 3/4/26 at 3:43PM. He observed the approximately 6-inch area of the wallpaper under the sink in the shared bathroom that had been cut and was held in place with 2 thumbtacks. The Director of Maintenance lifted the wallpaper held in place by thumbtacks which revealed a hole and exposed water pipes. He stated he was unaware of this issue, and the repairs were unacceptable and embarrassing. The Maintenance Director stated he had not observed the repair prior to this walking round and had not been notified of the repair. An observation of Resident #21/Resident #69's room was conducted with the Maintenance Director on 3/4/26 at 3:47PM. He observed the wallpaper patch that did not match the rest of the wallpaper behind the toilet in the shared bathroom; the patch was stapled in place. The Maintenance Director stated the wall repair appeared to be related to a major plumbing issue and the access needed was not properly repaired. The Maintenance Director stated he was unaware of the repair and that it was unsettling and unacceptable and not to facility standards. He further stated he did not have a work order for this room and had not been notified. The Administrator was interviewed on 03/04/26 at 3:55PM. She stated she was unaware of the way the repairs had been completed in Resident #21/Resident #69, Resident #28/Resident #72's shared bathrooms. The Administrator indicated she was not aware Resident #9, Resident #21/Resident #69, Resident #28/Resident #72's rooms were not clean, and it was unacceptable to have dirty resident rooms. The Administrator stated she did not know why the Housekeeping Director and Maintenance Director were unaware.