STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345433	A. BUILDING _____ B. WING _____	04/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

(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 371 SS=F	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, policy review and staff interview, the facility failed to label and date foods in the freezer, failed to use thawed meat within 72 hours, failed to dispose of tea after 72 hours, and dispose of frozen leftovers within six months. The findings are: A. The policy Sanitation & Food Production with a revised date of 6/09 stated that "Thaw frozen meats for 48 - 72 hours in advance to ensure the meats is completely thawed." On 4/25/11 at 1:11 PM observations of food storage in the kitchen with the Dietary Manger (DM) revealed two ten pounds tubes of ground beef that was dated as being removed from the freezer on 4/22/11. The stamped expiration date by the manufacturer was 4/1/11. Per the DM, this ground beef was to be used for meat loaf. Review of the menus for the week revealed meat loaf was on the menu for Tuesday 4/26/11. Interview with the DM on 4/28/11 at 10:15 AM revealed that new ground beef was purchased for the meatloaf that was	F 371	**This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law** 1) The ground beef, the frozen vegetables, tea, and chili were discarded by the Dietary Manager. 2) A complete audit of the freezer and cooler were made by the Dietary Manager to ensure policy was being followed on proper thawing of meats, labeling and dating all foods. 3) Education to the Dietary staff by the Registered Dietician on May 19, 2011 regarding the policy and procedure for proper thawing of meats, labeling and dating of all foods. QI audits of proper thawing of meats, dating and labeling of food to be completed by Dietary Manager daily x 2 weeks then weekly thereafter. In addition, the Administrator will conduct QI audits for proper labeling of food weekly x 4 weeks then monthly thereafter. 4) Findings of the QI audits to be presented to the RM/QI committee by the Dietary Manager monthly x 12 months to determine need for further education and/or monitoring. RECEIVED MAY 16 2011 BY:	5-20-2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alicia Barry, BS, NHA — TITLE: Administrator — (X6) DATE: 5-13-2011

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.

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F 371	Continued From page 1 served on 4/26/11. She further stated that she thought the handwritten date of 4/22/11 was probably the date the ground beef was removed from the cardboard box in the freezer and not really moved to the refrigerator to be thawed until Sunday night 4/24/11. B. The policy Sanitation & Food Production with a revised date of 6/09 stated "Rotate/use all leftover food items within 72 hours (or per state/local regulations) of noted storage date on labels." On 4/25/11 at 1:11 PM observations of the reach in refrigerator revealed a large container of sweet tea dated as having been made on 4/21/11 located along the back wall of the reach in refrigerator. Interview with the Dietary Manager (DM) at this time revealed that sweet tea was kept up to one week. Follow up interview with the DM on 4/28/11 at 10:15 AM revealed she would keep the tea 4 to 5 days once made unless it looked cloudy. C. The policy for Food Labeling Reference Guide dated 6/09 stated "Keep items in original delivery cardboard case from vendor whenever possible. Put delivery date on cardboard case. Put delivery date on individual items (cans, bags etc.) when removed from cardboard delivery case. When food item is opened and not completely used, write the open date on the food container. Write a use by date on the food container." On 4/25/11 at 1:11 PM observations with the Dietary Manger of the freezer revealed two sealed bags of island blend frozen vegetables and one sealed bag of frozen green beans with no dates. There was also one opened bag of frozen cauliflower and one opened bag of mixed vegetables without dates of when they were delivered in a cardboard	F 371		

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F 371	Continued From page 2 box or when they were opened. At this time the DM stated that dates should be put on the bags when removed from the cardboard boxes and when opened. Follow up interview with the DM on 4/28/11 at 10:15 AM revealed that she believed the frozen vegetables were removed from the cardboard box and opened over the weekend but that the bags should have been dated. D. The policy for Food Labeling Reference Guide dated 6/09 stated that frozen meats has a "use by" date of 6 months. On 4/25/11 at 1:11 PM the freezer contained a large container of leftover frozen chili dated 9/30/10. The Dietary Manager (DM) disposed of this container and stated the leftovers in the freezer were good for 6 months. Follow up interview with the DM on 4/28/11 at 10:15 AM revealed it was her responsibility to ensure the freezer items were within 6 months use by date and she just missed it on her weekly rounds.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	1) The DON placed a container with gowns, masks, gloves, etc in the hallway right outside Resident #34's door. 2) Residents currently on Contact Precautions have a sign was placed outside of their door instructing staff and visitors to see the nurse prior to entering the residents room. In addition, a container with gowns, masks, gloves, etc. has been placed in the hallway outside of the residents' room by the DON.	

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F 441	Continued From page 3 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, medical record and facility documentation review, and facility staff interviews, the facility failed to meet infection control standards for one (1) of one (1) sampled residents who was identified as having an active infection with a multi-drug resistant bacteria known as Extended Spectrum Beta Lactamase (ESBL). (Resident # 34) The findings are: A review of the facility's policy entitled, "Infection	F 441	3) Education to staff regarding Infection Control policy and procedures including specific policy on Contact Precautions was given by the DON on May 12th, 2011. Residents currently needing Contact Precautions had their Care Tracker Profile updated and an information sheet added to their MAR on May 12th, 2011 by the DON and Infection Control Nurse to inform nurses and nursing assistant about the residents' status. 24hr reports are reviewed M-F in the clinical review meeting and infections noted by Infection Control Nurse for follow through on appropriate interventions. Infection Control Nurse to ensure adequate supplies are immediately available for staff use with resident on Contact Precautions. Infection Control nurse, Shift Supervisor, and/or the DON will communicate via 24hr report, Care tracker Profile, and education to the nursing staff when it is necessary for a resident to have any special precautions. QI audits regarding infection control interventions used with a resident requiring Contact Precautions to be completed by the DON daily x 2 weeks, weekly x 4 weeks then monthly thereafter. 4) Findings of the QI audits to be presented to the RM/QI committee by the Infection Control nurse and/or DON monthly x 12 months to determine need for further education and/or monitoring.	5-20-2011

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F 441	Continued From page 4 Prevention", noted as being revised on 02/2009 specified; "The facility will utilize Contact Precautions in addition to Standard Precautions, or the equivalent, for specified resident/patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the resident/patient or indirect contact with environmental surfaces or resident/patient care items in the resident/patient environment." The policy addressed using personal protective equipment such as gown and gloves when entering the resident's room and having contact with the resident, environmental surfaces, or items in the resident's room. The policy under "Visitors" indicated that a sign be placed on the resident's door instructing visitors to report to the Nurse's Station prior to entering. The sign did not address what measures were to be implemented to prevent the spread of microorganisms when staff or visitors had direct or indirect contact with the resident with a known infection. Resident #34 was readmitted to the facility on 11/03/10 with diagnoses including Hemiplegia, and Urinary Tract Infection. The most recent Minimum Data Set (MDS) Annual Assessment dated 03/25/11 indicated the resident had short or long term memory deficits, and dependant with one (1) to two (2) person physical assist for activities of daily living including transfers, bed mobility, eating and personal hygiene. The resident was also noted to have an indwelling urinary catheter and was incontinent of bowel. Review of the resident's medical record review revealed a laboratory report of a Urine Culture and Sensitivity that specified the resident was	F 441		

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F 441	Continued From page 5 positive for "ESBL" on 03/12/11 and 04/22/11. A Report of Consultation dated 04/27/11 indicated that no evidence of infection in her sacral pressure ulcer was present. Observations of Resident #34's room on 04/27/11 at 4:50 p.m. revealed a sign on the door that read "Please See Nurse Before Entering Room." The resident was not observed in the room. An interview on 04/27/11 at 4:54 p.m. with Licensed Nurse (LN) #1 revealed that the resident was out of the facility for a doctor's appointment and the sign on the door indicated that the resident was on contact precautions due to an infection in her sacral pressure ulcer. LN #1 states that if asked by a visitor they would be instructed to wear gloves and a gown if touching the resident and a cart holding those supplies is typically placed outside the resident's room. LN #1 indicated that the resident may no longer be "contagious" and would verify her status. On 04/28/11 at 12:45 p.m. LN #1 was observed feeding Resident #34's without gloves or a gown. At 1:25 p.m. LN #1 stated that no gloves or gown was required while feeding the resident because she was not handing any infectious material. An interview with NA #1 on 04/28/11 at 2:00 p.m. revealed that she routinely cares for Resident #34 and that gloves (no gown) are always worn when providing personal care. NA #1 confirmed that the resident was on contact precautions due to an infection in her wound and that her urine had been a "problem in the past" but the resident has been on an antibiotic. NA #1 stated if a gown was needed they were located in the clean utility	F 441		

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F 441	Continued From page 6 room. On 04/28/11 at 4:00 p.m. an interview was conducted with the Director of Nursing (DON) who managed the Infection Control Program for the facility. The DON stated that Resident #34 has had a complex history and had been on contact precautions since August 2010 for infections in her wound or her urine. Current precautions were implemented due to ESBL bacteria in her urine. The DON stated that Resident #34 was the only resident with an active infection and it was her expectation that staff use gloves and gown when providing care. The DON stated that the facility did not educate visitors or other residents that a resident had an infection or what necessary precautions were to be taken to prevent exposure or the spread of the infection unless specifically asked.	F 441		