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 ______	C 09/20/2013

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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and family and staff interviews the facility failed to notify the responsible party regarding an injury for 1 of 3	F 157	This Plan of Correction (PoC) does not constitute an admission or agreement by Clay County Care Center of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This PoC is prepared solely because it is required by state and Federal law. **F157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC.)** A. Resident # 55 no longer resides at the facility. B. All residents have the potential to be affected by this citation. A review of resident's charts for notification for change in condition was completed 9/21/13-10/4/13 by the Director of Clinical Services, Nurse Manager and Executive Director and any discrepancies identified were corrected and the responsible and physician were immediately notified by the resident's nurse at that time.. C. Licensed Nurses and Certified nurse assistants were in-serviced by the Director of Clinical Services/Regional Director of Clinical Services/Nurse Manager	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gary D. Corbett [signature] Executive Dir. — TITLE — (X6) DATE: Revised 10/16/13

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.

original signature 10-13-13mh

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F 157	Continued From page 1 residents reviewed for notification if change. (Resident #55) The findings included: A Situation, Background, Assessment, and Recommendation form dated 09/11/13 located in Resident #55's medical record revealed a functional status change of "abrasion/wounds to toes". Assessment on this form read as follows: "Resident was being wheeled in parking lot by SW (Social Worker), feet were dragging under wheelchair." Nursing note section of this form timed 7:10 PM read, "This nurse called to shower room by DCS (Director of Clinical Services) and another nurse. Resident in shower room in wheelchair upon assessment, resident house shoes torn and covered in blood at the toes of the shoes. Further assessment of resident ' s foot reveal abrasions on great toe and 2nd and 3rd toe on right foot. Deep abrasions on all 4 toes on left foot and abrasion on great toe on left foot. Resident wounds cleaned and treatment orders received." Also indicated on this form was family notified 09/12/13 at 10:10 AM and physician notified 09/12/13 at 10:15 AM. This form was signed by the Unit Manager. On 09/17/13 at 10:30 AM an interview was conducted with Resident #55's Responsible Party (RP). The RP stated she had not been notified of Resident #55's injuries until the next day (09/12/13) at 11:30 AM. She stated the facility called to tell her Resident #55 would be seen at the wound clinic. The RP stated they did not tell the extent of the wounds just that she had some abrasions. An interview was conducted on 09/17/13 at 1:14	F 157	on notifying responsible party and physician of significant changes in resident condition on 10/4/13-10/13/13. Newly hired Licensed Nurses and Certified Nurse Assistants will be educated by the Director of Clinical Services/Nurse Manager during the orientation process on notifying responsible party and physician of significant changes in resident condition. D. The Director of Clinical Services and/or Nursing Manager will conduct Quality Improvement monitoring of 10 resident charts for notification to the responsible party and physician of changes in condition five times a week for one month, three times a week for two months, two times a week for one month and one time a week for 1 month. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly for 6 months and/or until substantial compliance is obtained.	October 14, 2013.

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F 157	Continued From page 2 PM with the Administrator. He stated he did not know when the family or the doctors were notified. The Administrator stated the doctor and the family should have been notified immediately after the accident had occurred. An interview was conducted on 09/19/13 at 5:08 PM with Unit Manager (UM). The UM stated she did not call the resident's RP that night (09/11/13) because she thought someone else had called the resident's RP. She stated she realized the next day the RP had not been called so she called her that morning. The UM explained usually it is the first nurse who deals with the resident who has had an incident or an accident that notifies the RP.	F 157		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record reviews, and staff interviews, the facility failed to provide oral care for 1 of 3 sampled residents. (Resident #3). The findings included: Resident #3 was admitted to the facility on 09/30/11 with diagnoses which included multiple sclerosis and quadriplegia. The most recent	F 312	**F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** A. Resident # 3 had oral are provided on 9/19/13 by a certified nurse aide. B. All residents have the potential to be affected by this citation. An audit of resident's mouths was completed 9/19/13 by the Director of Clinical Services and Nurse Manager. C. Licensed Nurses and Certified nurse assistants	

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F 312	Continued From page 3 annual Minimum Data Set (MDS) dated 01/14/13 revealed the resident was cognitively intact. The MDS specified the resident was totally dependent on staff assistance for bathing, personal hygiene, and eating. A Care Area Assessment (CAA) dated 01/14/13 specified Resident #3's needs were planned for total assistance with two persons for all bathing and hygiene. The CAA also included under functional and rehabilitation potential Resident #3 needed oral care provided routinely and as needed. A review of nursing notes revealed no documentation describing the resident had refused care. On 09/17/13 at 12:45 PM, Resident #3 was observed lying in bed. Resident #3 was observed with white and yellow film that covered teeth prior to the lunch tray being served. The resident was observed receiving assistance with lunch. At this time Resident #3 stated she would like to have oral care provided and that it had not been offered. On 09/18/13 at 10:45 AM, Resident #3 was observed during bathing, personal hygiene, and dressing. Nursing Assistant (NA) #5 and NA #6 assisted the resident with care. Resident #3 received a bed bath, lotion applied to skin, and deodorant was applied to underarms. Resident #3 was dressed in a clean gown and positioned according to her preferences. No oral care was provided. An interview was conducted on 09/18/13, at 10:49 AM with NA #6. He stated oral care should be	F 312	were in-serviced by the Director of Clinical Services, Regional Director of Clinical Services and/or Nurse Manager providing oral care 10/4/13-10/13/13. New hired Licensed Nurses and Certified nurse assistants will be oriented by the Nurse Manager on providing oral care. D. The Director of Clinical Services and/or Nursing Manager will conduct Quality Improvement monitoring of oral care of 10 dependent residents five times a week for one month, three times a week for two months, two times a week for one month and one time a week for 1 month. The results of these audits will be ported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Activities Director, Medical Director, Social Services,	

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F 312	Continued From page 4 offered in the morning before breakfast and in the evening. NA #6 stated he did not provide oral care because it was his understanding oral care was provided by third shift staff before breakfast. An interview was conducted on 09/18/13 at 11:08 AM, with NA #5. She stated she had worked with Resident #3 and was familiar with her needs. NA #5 further stated Resident #3 required total assistance with bathing, personal hygiene, and eating. NA #5 stated she had not preformed mouth care on Resident #3 and she had not offered to provide mouth care. Oral care was not provided on 09/18/13 by NA #5 and she was taught oral care was part of daily care of a resident. NA #5 did not offer a reason for not providing oral care. On 09/18/13 at 11:10 AM, Resident #3 was observed lying in bed. The resident was observed with white and yellow film that coated her teeth. At this time Resident #3 stated she would like to have oral care provided and that it had not been offered. The resident indicated the nursing assistants who had provided care earlier this morning were NA #5 and NA #6. An interview was conducted on 09/18/13 at 11:30 AM, with Nurse #2. She stated her expectations were for the nursing assistants to provide oral care for residents. She further included Resident #3 was unable to provide oral care on her own and it should be part of the resident's daily care. An interview was conducted on 09/18/13 at 2:36 PM with NA #3. She revealed she had cared for Resident #3 on 09/17/13. She further explained Resident #3 required total assistance with bathing, personal hygiene and eating. NA #3	F 312	Maintenance Director, Minimum Data Assessment Nurse.	October 14, 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	Continued From page 5 stated she did not offer mouth care to Resident #3 on 09/17/13 and that she should have offered mouth care after the resident ate lunch. NA #3 did not have an explanation for why she had not offered mouth care. An interview was conducted on 09/19/13 at 3:17 PM, with the Director of Nursing (DON). She stated her expectations were for the nursing assistants to provide mouth care to residents during assigned showers and more frequently as resident's needed. The DON further explained Resident #3 was not provided mouth care and this did not meet her standard. The DON also stated residents should be offered mouth care daily and as frequently as needed.	F 312		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on facility policy, record review, and staff interviews the facility failed to prevent a resident from an injury, which required amputation, while being pushed in her wheelchair with no footrests and wearing cloth slippers for 1 of 3 residents reviewed for supervision to prevent accidents. (Resident #55)	F 323	**F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES** A. Resident # 55 no longer resides at the facility. B. All residents who use a wheelchair have the potential to be affected by this practice. Current facility residents were reviewed by the Director of Clinical Services/Nurse Manager on September 18, 2013 for possible injury potential. No other residents were noted to have any injuries related to this practice.	

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F 323	Continued From page 6 Immediate Jeopardy began on 09/11/13 when Resident #55 was pushed in her wheelchair in the parking lot of the facility with no footrests and wearing cloth slippers resulting in severe in injuries to her feet which required amputation. Immediate Jeopardy was removed on 09/20/13 when the facility provided and implemented a credible allegation of compliance. The facility will remain out of compliance at a lower scope and severity of a level D (No actual harm but a potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. The findings included: The facility's policy entitled "General Guidelines for Wheelchair Seating" dated 09/01/2011 read in part: "12. Use of leg rest panels assist in the prevention of knee flexion contractures and the legs and feet falling off of the leg rests, dangling and getting injured." Resident #55's most recent admission to the facility was 07/24/13 with diagnoses which included end stage renal disease, dialysis dependent, diabetes, peripheral vascular disease, and chronic lower extremity wound. Resident #55's most recent 5 Day Minimum Data Set (MDS) dated 07/31/13 revealed she had moderate cognitive impairment. The MDS further assessed Resident #55 as needing the extensive assistance of two people with locomotion on unit and limited assistance of one person off unit. Resident #55 was further coded on the MDS as having a trunk restraint which was used daily. Resident #55's care plan, updated 07/31/13, for	F 323	Residents with diabetes and vascular issues that utilize wheelchairs as primary mode of mobilization will be assessed daily for open areas, discoloration and blisters by the Director of Clinical Services/Nurse Manager/Charge Nurse. On September 11 & September 12, 2013, the Director of Clinical Services and Nurse Manager assessed all residents who utilize wheelchairs. Residents that require assistance propelling themselves in their wheelchair had leg rests/foot pedals applied to their chairs or readily available. Residents self propelling their wheel chairs will remain without leg rests on their chairs, unless being propelled by a staff member. Residents who self-propel were assessed for safety and proper positioning of feet. On admission, at risk residents will be assessed for proper footwear, wheelchair locomotion and any medical conditions that would affect mobility. Proper footwear will be furnished by the facility	

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F 323	Continued From page 7 potential for adverse side effects related to the use of psychotropic medications had an intervention included which read, "with increased behaviors may take resident outside for fresh air." The care plan did not address the protection of Resident #55 feet. A Situation, Background, Assessment, and Recommendation (SBAR) form dated 09/11/13 located in Resident #55's medical record revealed a functional status change of "abrasion/wounds to toes". Assessment on this form read as follows: "Resident was being wheeled in parking lot by SW (Social Worker), feet were dragging under wheelchair." Nursing note section of this form timed 7:10 PM read, " This nurse called to shower room by DCS (Director of Clinical Services) and another nurse. Resident in shower room in wheelchair upon assessment, resident house shoes torn and covered in blood at the toes of the shoes. Further assessment of resident's foot reveal abrasions on great toe and 2nd and 3rd toe on right foot. Deep abrasions on all 4 toes on left foot and abrasion on great toe on left foot. Resident wounds cleaned and treatment orders received." Also indicated on this form was family notified 09/12/13 at 10:10 AM and physician notified 09/12/13 at 10:15 AM. This form was signed by the Unit Manager. On 09/12/13 Resident #55 was taken to the wound clinic. Notes from this encounter indicated due to the severity of the injury and potential for complications Resident #55 would have to be transferred to the local hospital. Physical exam results indicated "deep tissue abrasions over joints of several toes of both feet. The abrasions go down to the joint."	F 323	within 24 hours, as needed. C. On September 18, 2013, Licensed Nurses and Certified Nursing Assistants and Administrative staff were in-serviced by the Director of Clinical services and/or Nurse Manager regarding the facility policy and procedure for maintaining residents' safety during wheelchair transport including: proper supervision of foot placement; positioning of feet in wheelchair footrests and proper footwear that covers the foot; location of wheelchair foot rests for ready application; and location and availability of wheelchairs with foot rests/leg extenders near the main entrance to the facility. Staff will not be permitted to work until they are inserviced. Future staff will be educated during orientation. Staff will be trained to position the residents' feet in the middle of the footrests during transport. Staff will maintain visual observation of residents during transport to	

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F 323

Continued From page 8

On 09/12/13 Resident #55 was seen at the local hospital. Notes from this encounter indicated Resident #55 had suffered toe injuries with deep abrasions with visible muscles and tendons. Orders were written for the resident to be transferred to the trauma center hospital as the level of care/service was not available due to Resident #55's need for nephrology and orthopedic care.

Hospital records from the trauma center dated 09/16/13 read in part, "...due to peripheral vascular disease and foot wounds, the resident underwent Transmetatarsal amputation of her left foot and debridement of her right foot."

During an interview on 09/17/13 at 12:34 PM with the Unit Manager she stated the Director of Clinical Services (DCS) and the Administrator asked her to help assess the resident. She stated they took the resident to the shower room. The DCS was also in the shower room. The Unit Manager stated she noted the resident's cloth slippers were torn in the toe area. She stated she could see the resident's toes through the end of the slipper and there was obvious blood around the toe area of the slippers. She asked what happened and the DCS told her the resident's feet got caught under her while she was in the wheelchair. They removed her shoes and assessed her toes. On the right foot, the great toe and the second and third toe all had abrasions. The second toe on the right foot had the deepest abrasion. On the left foot all toes had deep abrasions on the knuckle area. The toes were curled under on the left foot but not the right foot. She cleaned the foot and did a wet to dry dressing on both feet and wrapped them in

F 323

maintain proper positioning of feet. Staff will be educated on ensuring Residents have protective footwear when out of bed. All licensed staff will be inserviced on diabetes and its disease processes and complications related to vascular issues.

D. The Director of Clinical Services and/or Nursing Manager will conduct Quality Improvement monitoring regarding the facility policy and procedure for maintaining residents' safety during wheelchair transport including: proper supervision of foot placement; positioning of feet in wheelchair footrests and proper footwear that covers the foot; location of wheelchair foot rests for ready application of 10 residents who are wheelchair bound five times a week for one month, three times a week two months, two times a week for one month and one time a week for 1 month.

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F 323	Continued From page 9 gauze. The resident yelled out while she (the Unit Manager) was cleaning her feet but when asked if she was in pain she said no. The Unit Manager stated she called the on call physician to get the order for the wound care and he told her to notify the primary physician in the morning. She told the on call doctor what had happened to the resident. She stated the resident did not normally drag her feet. The resident would self propel and was usually very good about lifting her feet. It was common for the resident to be taken outside by the staff when she was yelling. She stated the next day she received an order to send the resident to the wound clinic. The Unit Manager explained when the resident was seen at the wound clinic the person who transported her from the facility called to inform them Resident #55 was being sent to the hospital. An interview was conducted on 09/17/13 at 1:14 PM with the Administrator. He stated Resident #55 had come back from dialysis and she was calling out consistently. The resident was yelling and he could hear her from his office. The Social Worker (SW) was the liaison that night. He explained the liaison was an administrative person who took turns staying until 8 PM to "help out". The Administrator asked the SW to take Resident #55 for a walk outside. Sometimes it would calm her. The SW was walking around the building on the sidewalk. The Administrator stated he went outside and met the SW and resident #55 on the sidewalk, The Administrator stated he happened to look down and saw blood and then he saw the resident's feet. He told the SW to get a nurse and he stayed with the resident to calm her. She was still yelling out and he asked her if she was hurt and she did not respond to his question. They took her in and DCS was asked	F 323	The results of these audits will be ported to the Quality Assurance Performance Improvement Committee for 12 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Activities Director, Medical Director, Social Services, Maintenance Director, Minimum Data Assessment Nurse.	October 14, 2013

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F 323	Continued From page 10	F 323		

to assist in taking care of her wounds. He stated he saw blood on the sidewalk. He did not know how long they walked. He stated he had taken the resident for a walk before and she would hold her feet up or pedal along. He stated she would propel herself around the facility so that was why she did not have foot rests on the wheelchair. He stated he would have expected the SW to have noticed that the resident was dragging her feet and assessed to make sure the resident was not dragging her feet. After she was brought in the Unit Manager assessed the resident and dressed the wounds.

During an interview on 09/17/13 at 1:59 PM with the Administrator he stated he had not thought of the need for the resident to have foot rests while staff was walking her outside. He stated Resident #55 had continued to intermittently scream while she was outside and when he went out to speak to the SW she was screaming. He stated now after the incident occurred with the resident's injuries he did see the need for her to have had footrests on her wheelchair.

An interview was conducted 09/17/13 at 2:05 PM with the Physical Therapist (PT) who stated she was familiar with Resident #55. The PT stated the resident did not need the foot rests while she was propelling herself in the facility but she was weak so she should have had them if she was going to be pushed in her wheelchair for a long walk.

During an interview on 09/17/13 at 3:55 PM the Director of Clinical Services (DCS) stated she was in the conference room when the Administrator came in and stated, "I need you". She stated she told staff to get towels to wrap the resident's feet as the slippers where bloody and

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 ____	C 09/20/2013

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 323	Continued From page 11	F 323		

there was a trail of blood. The slippers were fleece and came half way up her calf and soles had non skid treads. The toes were opened at the toe seam and were bloody. She stated Resident #55 was taken to the shower room and she told the nurses to bring the treatment cart to the shower room. She stated she took the towels and slippers off and sprayed her feet with the shower spray nozzle. The toes on her left foot were contracted around and the nails were under foot and the toes were abraded to the second knuckle. The wounds were beefy red. She stated the wounds on the right foot were on the tips of her toes and the nails. From what she could tell the nails were intact on the left foot. The Unit Manager dressed the wounds and called the on call doctor. She stated he told the Unit Manager to call Resident #55's regular physician in the morning. She explained after the first walk the SW brought Resident #55 back in and took her to her room. A few minutes later the Administrator asked the SW to take the resident outside for another walk. She stated when they brought the resident back into the building there was a streak of blood noted near the front door and a streak closer to the nursing office which she noticed as they were bringing the resident into the shower room. She pointed the bloody streak out to the Administrator and the SW. The regular physician did not see Resident #55 but gave the order to send her to the wound clinic. The wound clinic called and stated they wanted to send her to the hospital. She stated in hind sight, yes, the resident should have had footrests on her wheelchair.

An interview was conducted on 09/18/13 at 9:07 AM with Nursing Assistant (NA) #1 who had worked first shift with Resident #55 the day of her

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 ____	C 09/20/2013

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 323	Continued From page 12 accident. NA #1 stated she worked with her the next day as well. She stated she was given report on the morning of 09/12/13 from 3rd shift. They reported to her that the SW took Resident #55 into the parking lot to push her to see if it would calm her down. She explained the SW failed to notice that the resident's foot pedals were not on. Her feet were dragging under the wheelchair on the pavement. She wore knit boots that came up her calves that the NA had put on her in the morning. NA #1 stated the resident usually had the foot pedals on her wheelchair and she thought the resident left to go to dialysis with the foot pedals on her wheelchair the day of her accident. NA #1 stated when Resident #55 would propel herself in her wheelchair her feet touched the ground. Resident #55 did not wear shoes. She always wore something soft because of her contractures. She had been working with Resident #55 for a couple of months. She stated "you would have to really watch because her feet were contracted and they had dropsy". She stated if she had the foot pedals on her feet would sit on them flat but if she did not use foot pedals her feet would drop down. The resident did not pedal around the facility much. She was very sick and she would get tired and then say "push me". She stated you had to be very careful when pushing her because of the way her feet dropped. NA #1 explained when she did propel, which was very little, she would use her toes or the tips of her feet. The only time she ever saw her feet flat was when they were on the foot pedals. She asked the resident the morning of the 09/12/13 if she was hurting and she said "yes". NA #1 was helping the nurse dress the wounds and she asked the resident if she was in pain and she said "yes" and Nurse #1 went to get her something for pain. NA #1 reported the wounds on the left foot	F 323		

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 ______	C 09/20/2013

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 323	Continued From page 13	F 323		

were deep holes/craters. She stated it was bad. She could not believe how bad it was.

An interview was conducted on 09/18/13 at 9:50 AM with Nurse #1. She revealed the resident could self propel a very short distance out of her room or a short distance in the hall. She could not propel herself to meals. The resident did have foot rests but not always. The nurse stated she had held up her feet while the nurse was taking her to activities and to restorative dining. The cloth slippers she usually wore were made of thick fleece fabric. Nurse #1 stated she was not here on the 09/11/13 when the injury occurred. She received report that Resident #55 had some abrasions on her toes and she saw the dressing needed to be changed as it had blood on it and it was due to be changed anyway. The wounds were wrapped in gauze and taped and she saw blood coming through the bandages. When she took the dressing off the gauze was stuck and she had to get wound cleanser to spray on the wounds to loosen the gauze. The resident did have pain before she did the dressing change as the resident would pull her foot away. The knuckles were scrapped and the 2nd and 3rd toes had big red craters filled with thick blood. As she got to the forth toe it had a deep crater but was not filled with blood. The toes were raw and either the third or the forth toe appeared to be deep and down to the bone. She could tell it was hurting the resident as she did the dressing change. She then dressed the foot and sent her to the wound clinic. Using the foot rests for this resident was a usual because she would sleep a lot.

On 09/18/13 at 10:20 AM an interview was conducted with the Physical Therapy Assistant

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 ______	C 09/20/2013

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 323	Continued From page 14 (PTA) who had been working with Resident #55. The PTA stated he had been working with her to try to increase her strength. He stated the resident was weak and she would only be able to hold her feet up for short distances. A telephone interview was conducted on 09/18/13 at 4:44 PM with the Social Worker (SW). He stated it was about supper time when he went down to the dining room and Resident #55 was screaming. She had eaten a little of her supper and she said she did not want anymore. He stated he did not notice anything wrong with her feet before taking her outside for a walk. The SW stated they were outside for 15-20 minutes. He stated he did not notice any problem. When walking her around he did not look down at her feet. Resident #55 was wearing her lap buddy. He explained her position in wheelchair was sitting straight up but that she did lean forward a time or two. The SW stated she would sit back then lean forward 30 seconds to one minute then lean back. He stated as far as he knew she was still holding her feet up. He stated he did see her holding them up but did not check to see how far off the ground they were. He stated he did not notice anything wrong with her feet. He went on to explain he let her rest, put her feet on the ground and then started pushing her around again. He stated he did not look at her feet very often. The SW indicated the resident was wearing cloth slippers that came up her calf like a boot. He stated he rolled Resident #55 in parking lot and down sidewalk. He went on to say he took her back into the facility and she started to scream. He stated when he brought her back in. He did not notice any blood. He stated the Administrator asked him to take her back outside. The SW verified she screamed intermittently	F 323		

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 ______	C 09/20/2013

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 323	Continued From page 15	F 323		

during the first walk and progressively more during the second walk. He stated he took Resident #55 outside for another 15 minutes at which time he was near the front porch. He stated the Administrator came to tell him he was going too fast while walking with her. He stated he walked at his usual pace but he would consider himself to be a fast walker. He was talking with the Administrator for a few minutes when the Administrator noticed the blood. He stated he did not see blood until then. He stated her toes appeared to be rubbed off. He stated he did not know where they got rubbed off. The fabric on her slippers was torn where toes were. There was a lot of blood that was soaked through the material. He stated the Administrator pointed it out. The SW stated they immediately took her back in the facility and got the DCS. The SW explained he wrote a statement about what happened and left facility the about 8:20 PM. The SW stated he couldn't tell a difference with her screaming whether it was her normal state or if she was in pain. He stated he should have immediately put on the leg rests so she would not have to hold up her legs. He does not know if she had footrests for her wheelchair. He stated he should have stopped and asked her to pick up her feet.

An interview was conducted on 09/19/13 at 8:37 AM with NA #1 who had worked with Resident #55 the morning of 09/11/13. She stated when she came in that morning Resident #55 was up, dressed, and wearing her cloth slippers. She stated her slippers were clean and with out holes.

During an interview on 09/19/13 at 4:05 PM the DCS she stated the resident did not have any other shoes that would have been more

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 ______	C 09/20/2013

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 323	Continued From page 16 protective. She stated she never saw her with anything other than the cloth booties. The DCS stated she thought the cloth slippers she was wearing were purchased by the family. To her knowledge the resident did not have any footrests for her wheelchair nor did she ever see her with footrests on her wheelchair. A telephone interview was conducted 09/19/13 at 4:52 PM with the County Transport Person who transported Resident #55 to and from dialysis. He stated Resident #55 had her foot rest on her wheelchair all of the time before the last state survey (08/16/13). He stated they were taped in place on her wheelchair with electrical tape. He stated she also had anti-tippers on her wheelchair. He stated after the last state survey he never saw the foot rests on her wheelchair again. During an interview on 09/19/13 at 5:08 PM the Unit Manager stated the resident had footrests that would be used for the resident when she was being transported to dialysis but when she was in the facility she did not use them as she self propelled. An interview was conducted 09/19/13 at 5:19 PM with Nursing Assistant #2 who worked with Resident #55 on the second shift. He stated he thought the resident had footrests on her wheelchair and he had noticed there was tape around the foam padding on the legs of the wheelchair. An interview was conducted on 09/20/13 at 10:03 AM with Nursing Assistant #3. She stated she worked with Resident #55 in the past and would transfer her to the restorative dining room and to	F 323		

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 ______	C 09/20/2013

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 323	Continued From page 17	F 323		

the bathroom. She reported the resident always had footrests and she made sure her feet were on the footrest. She stated she could not remember if there was any tape on the footrests.

An interview was conducted 09/20/13 at 10:11 AM with Nursing Assistant #4 who stated he remembered Resident #55 had footrests for a while. He stated he thought they might have broken. He stated he accompanied Resident #55 to dialysis and he would have to help her pick up her feet because she could not pick them up. Much of the time she was asleep because they would have to give her the medicine when she would scream. He stated Resident #55 would get medicine before she went to dialysis. He stated when he would come in at 7 AM she would be screaming and by the time we took her to dialysis she would be asleep.

The facility's Administrator was notified of the Immediate Jeopardy for Resident #55 on 09/18/13 at 4:30 PM. The facility provided a credible allegation of compliance on 09/20/13 at 3:30 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy:

Credible Allegation of Compliance (AOC)

IJ SUPERVISION TO PREVENT ACCIDENTS

Resident #55's most recent admission was on July 24, 2013. Admitting diagnoses are end stage renal failure, dialysis dependent nonadherence and non compliant, type two diabetes mellitus, hypertension and chronic lower extremity wounds.

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 ______	C 09/20/2013

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 323	Continued From page 18 On 09/11/13 Resident #55 was exhibiting her chronic habitual disruptive behavior of yelling out. She was rolled outside per care plan intervention in her wheelchair without foot rests attached by Social Services Director for a walk for approximately 10 minutes and then returned to the nursing unit. After returning to the nursing unit, she continued to exhibit repetitive noises and Resident #55 was asked if she would like to go outside again at which time she stated she did and was again transported in her wheelchair without foot rests attached for a walk by the Social Services Director. The Social Services Director did not supervise the placement of the resident's feet during the walk. While outside, blood was visualized on the resident's feet by the Executive Director. Resident #55 was then escorted to the shower room by the Director of Clinical Services, Executive Director and Social services. The resident's slippers were removed and her injuries were assessed. There was evidence of trauma to the right and left distal toes, left greater than right. The injuries were beefy red with no overt evidence of bone or tendon visible. The resident's status was reported to the on call physician on September 11, 2013 at approximately 8pm. Orders were received for the dressing treatment and the resident was transported to the wound clinic on 09/12/13 for evaluation. The resident was transported from the wound clinic to the local hospital for further evaluation and treatment of her injuries on both feet. All residents who use a wheelchair have the potential to be affected by this practice. Current facility residents were reviewed by the Director of Clinical Services/Nurse Manager on September 18, 2013 for possible injury potential. No other	F 323		

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 ______	C 09/20/2013

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 323	Continued From page 19	F 323		

residents were noted to have any injuries related to this practice. Residents with diabetes and vascular issues that utilize wheelchairs as primary mode of mobilization will be assessed daily for open areas, discoloration and blisters by the Director of Clinical Services/Nurse Manager/Charge Nurse. On September 11 & September 12, 2013, the Director of Clinical Services and Nurse Manager assessed all residents who utilize wheelchairs. Residents that require assistance propelling themselves in their wheelchair had leg rests/foot pedals applied to their chairs or readily available. Residents self propelling their wheel chairs will remain without leg rests on their chairs, unless being propelled by a staff member. Residents who self-propel were assessed for safety and proper positioning of feet. On admission, at risk residents will be assessed for proper footwear, wheelchair locomotion and any medical conditions that would affect mobility. Proper footwear will be furnished by the facility within 24 hours, as needed.

On September 18, 2013, Licensed Nurses and Certified Nursing Assistants and Administrative staff were in-serviced by the Director of Clinical services and/or Nurse Manager regarding the facility policy and procedure for maintaining residents' safety during wheelchair transport including: proper supervision of foot placement; positioning of feet in wheelchair footrests and proper footwear that covers the foot; location of wheelchair foot rests for ready application; and location and availability of wheelchairs with foot rests/leg extenders near the main entrance to the facility. Staff will not be permitted to work until they are in-serviced. Future staff will be educated during orientation. Staff will be trained to position the residents' feet

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	C 09/20/2013

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 323	Continued From page 20 in the middle of the footrests during transport. Staff will maintain visual observation of residents during transport to maintain proper positioning of feet. Staff will be educated on ensuring Residents have protective footwear when out of bed. All licensed staff will be in-serviced on diabetes and its disease processes and complications related to vascular issues. Immediate Jeopardy was removed on 09/20/13 at 2:10 PM. Observation revealed all residents, who were identified as wheelchair dependent and at risk for injury when being pushed in their wheelchair had footrests in place. Interviews conducted with staff in all departments and who worked on all shifts confirmed that they had received in-service training on the facility's policy and procedure regarding wheelchair transfers.	F 323		