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 10/28/2014

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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		12/5/14

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

Electronically Signed | 11/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1	F 156		

funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide 3 of 3 sampled residents with a written explanation as to the reason their Medicare benefits were ending. (Residents #13, #46, and #61). The findings included: 1. Resident #13 was readmitted to the facility from a hospitalization on 05/07/14. Her diagnoses included anemia, hypertension, peripheral vascular disease and diabetes. Review of the Notice of Medicare Non-Coverage letter for Resident #13 revealed her medicare services were ending on 07/24/14. The form letter stated that the "Medicare provider and /or health plan have determined that Medicare probably will not pay for your current _____ (blank spot to fill in information) services after the effective date indicated above. You may have to pay for any services you receive after the above date." In the blank spot was hand written the word "Medicare." The form did not include what specific services were ending or what services would have to be paid for if they continued. Interview with the Business Office Manager on 10/14/14 at 4:02 PM revealed the social worker (SW) completed the forms and she just filed them. Interview with the SW on 10/15/14 at 2:32 PM	F 156	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. No resident was injured related to this citation. 2. All residents have the potential to be affected by this citation. Residents that are skilled under Medicare Part A and/or B will be discussed weekly at the Medicare meeting to determine the reason that the service will be stopping and the date the Medicare benefit cut letter needs to be to the resident and/or family. The Social Services Director will supply the letter to the family, resident and/or responsible party. Review of the last 30 days of Medicare benefit cut letters was reviewed by the Executive Director 11/24/2014. 3. The Social Services Director, Business Office Manager, Minimum Data Set Nurse and Executive Director were in serviced 11/24/2014 by the Regional Case Mix Coordinator. The Executive Director and/or Business Office Manager will perform Quality Improvement Monitoring of Medicare benefit cut letters 2 times a week for 3 months, 1 time a week for 1	

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F 156	Continued From page 3 revealed that medicare residents were discussed in morning meeting with therapy and nursing and a determination of the status of medicare with possible discharge dates was discussed then. She stated she normally got 4 days notice before skilled care ended to send the letter. She stated that therapy provided her a sheet of the reasons for therapy ending which she verbally shared with the resident and/or responsible party. SW was unable to provide documentation of the reason Resident #13's Medicare was ending. SW stated on follow up interview on 10/15/14 at 3:06 PM that Resident #13 was under Medicare services for nursing care of anticoagulant therapy and diabetic management. 2. Resident #46 was admitted to the facility on 06/02/14 with diagnoses of urinary tract infections, dementia, mental disorders and a need for speech, physical and occupational therapies. Review of the Notice of Medicare Non-Coverage letter for Resident #46 revealed her medicare services were ending on 06/20/14. The form letter stated that the "Medicare provider and /or health plan have determined that Medicare probably will not pay for your current _____ (blank spot to fill in information) services after the effective date indicated above. You may have to pay for any services you receive after the above date." In the blank spot was hand written the word "Medicare." The form did not include what specific services were ending or what services would have to be paid for if they continued. Interview with the Business Office Manager on 10/14/14 at 4:02 PM revealed the social worker (SW) completed the forms and she just filed	F 156	month and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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F 156	Continued From page 4	F 156		

them.

Interview with the SW on 10/15/14 at 2:32 PM revealed that medicare residents were discussed in morning meeting with therapy and nursing and a determination of the status of medicare with possible discharge dates was discussed then. She stated she normally got 4 days notice before skilled care ended to send the letter. She stated that therapy provided her a sheet of the reasons for therapy ending which she verbally shared with the resident and/or responsible party. On 10/15/14 at 2:41 PM SW stated that therapies were ending for Resident #46. The form provided to her from therapy did not specify if the resident met her maximum potential or refused to participate or any other specific reason for the discontinuation of services.

3. Resident #61 was readmitted to the facility following a hospitalization on 07/03/14. His diagnoses included neuropathy, anxiety, nausea and vomiting, staph infection and need for therapy services. Review of the Notice of Medicare Non-Coverage letter for Resident #61 revealed his medicare services were ending on 08/04/14. The form letter stated that the "Medicare provider and /or health plan have determined that Medicare probably will not pay for your current _____ (blank spot to fill in information) services after the effective date indicated above. You may have to pay for any services you receive after the above date."

In the blank spot was hand written the word "Medicare." The form did not include what specific services were ending or what services would have to be paid for if they continued.

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F 156	Continued From page 5 Interview with the Business Office Manager on 10/14/14 at 4:02 PM revealed the social worker (SW) completed the forms and she just filed them. Interview with the SW on 10/15/14 at 2:32 PM revealed that medicare residents were discussed in morning meeting with therapy and nursing and a determination of the status of medicare with possible discharge dates was discussed then. She stated she normally got 4 days notice before skilled care ended to send the letter. She stated that therapy provided her a sheet of the reasons for therapy ending which she verbally shared with the resident and/or responsible party. On 10/15/14 at 2:41 PM SW stated that therapies were ending for Resident #61. The form provided to her from therapy did not specify if the resident met her maximum potential or refused to participate or any other specific reason for the discontinuation of services.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assess 1 of 1 resident observed with medications at bedside for the ability and safety to safely administer her own inhalers. (Resident #58).	F 176	1. Medications at bedside of resident #58 was removed on 10/14/2014 by the licensed nurse. Resident #58 no longer resides at the facility.	12/5/14

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F 176	Continued From page 6 The findings included: Resident #58 was admitted to the facility on 09/03/14 with diagnoses including chronic respiratory failure and chronic obstructive pulmonary disease. The physician orders dated 09/03/14 revealed she was ordered a Spiriva inhaler once per day, an Albuterol sulfate nebulizer treatment 4 times a day, Xopenex (an inhaler to prevent bronchospasms) as needed and a Symbicort inhaler twice a day. Review of telephone orders revealed on 09/04/14, the physician discontinued Xopenex. The admission Minimum Data Set (MDS) dated 09/12/14 coded her with intact cognition, limited assistance needed for most activities of daily living skills (ADLs) and utilizing oxygen. On 10/12/14 at 2:53 PM, Resident #58 was observed to have 2 inhalers on her bedside table. Symbicort which had a hand written date of 09/05/14 on the inhaler case and Xopenex. She stated she always kept them at bedside and used them when she needed them. On 10/14/14 at 5:26 PM, Nurse Aide (NA) #1 stated that she had seen and reported inhalers at bedside in the past. NA #1 stated that she had been told there was a physician's order for Resident #58 to keep the inhalers at bedside. Interview with the Resident #58's responsible party and the resident on 10/14/14 at 9:15 AM revealed facility staff took the inhalers away this date. The responsible party stated the resident was supposed to have them to use but that there was no physician's order to keep them at her	F 176	2. Residents who choose to self administer medications have the potential to be affect by this citation. New admissions will be interviewed to determine if they have a desire to self administer medications. Should they choose to then a clinical assessment will be done by the Director of Clinical Services and/or Nursing Supervisor. Observations for medications at the bedside was completed by the Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) 11/17/2014-11/19/2014. 3. The Director of Nursing and/or Nursing Supervisor in serviced licensed nurses on policy for assessing a resident for self administration of medications, notification to Director of Clinical Services if medications are found and receiving order from physician for resident to self administer 11/10/2014-12/04/2014. The Director of Nursing and/or Nursing Supervisor in serviced certified nurse assistants on notifying the licensed nurses should medications be found at the bedside 11/10/2014-12/04/2014 The Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) will perform Quality Improvement monitoring of 10 resident rooms for medications at the bedside 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks,	

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F 176	Continued From page 7 bedside. On 10/15/14 at 9:38 AM, Nurse #4 stated that the staff have taken inhalers out of the room on previous occasions. She stated she wrote a note to the physician to see if it was possible for the resident to keep inhalers at bedside but was currently unaware what had been decided about that. On 10/16/14 at 10:52 AM, the Director of Nursing (DON) was interviewed about medications kept at bedside. He stated the physician had to write an order for a resident to keep medications at bedside and the nurse, normally the Assistant Director of Nursing was responsible for completing the assessment for self administration of medications. He further stated that it was his opinion that Resident #58 could not self medicate. The DON presented a Resident Education Record which showed on 09/09/14 and on 09/15/14 Nurse #4 educated the resident that she was unable to keep inhalers at bedside or on person without a physician's order or evaluation by the physician. In addition, the DON presented a sheet that was filled out in morning meeting relating to "homework" that was assigned to specific staff to address certain problems identified in morning meeting. Review of these forms revealed the following: *undated sheet noted an inhaler at bedside and task to be completed was "order with (Doctor's name)?" The section relating to who this was assigned to was blank, the section relating to the completion was blank and the comment section stated "removed and educated family?" No specific information was included to determine if	F 176	1 time a week for 4 weeks and/or substantial compliance obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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F 176	Continued From page 8 this task was actually completed or the results. *on 10/01/14 there were 2 homework sheets completed in two separate handwritings. The first indicated Resident #58 was giving her own treatment/inhalers at bedside. The tasks to be completed was to educate resident and family or get order form the physician. This was assigned to the Assistant Director of Nursing. There was no information in the completed section or in the comment section to indicate if this was followed up on or the results. *the second homework sheet dated 10/01/14 noted the tasks to be completed was "neb-self admin? inhalers at BS." Under the assigned to column was "order to keep at BS (bedside)?" There was no information relating to any follow up to this task or results provided by the DON. Review of Resident #58's medical record revealed no assessment of her abilities to self administer medications and no physician's note or order relating the the resident's ability to self administer her inhalers.	F 176		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews,	F 242	1. Resident #100 was not injured related	12/5/14

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F 242	Continued From page 9 and record review, the facility failed to provide 1 of 5 sampled residents with the number of showers she preferred per week. (Resident #100). The findings included: Resident #100 was admitted to the facility on 04/17/14. Her diagnoses included Parkinson's disease, history of traumatic brain injury, dementia, gastroesophageal reflux, hypothyroidism and hyperlipidemia. The admission Minimum Data Set (MDS) dated 04/24/14 coded her with usually being understood and usually understands, having some inattention and disorganized thinking, having moderately impaired cognition (scoring a 10 out of 15 on the brief interview for mental status), requiring total assistance with bathing and limited assistance with hygiene and dressing. On 10/20/14 at 12:19 PM, the Admissions Director provided a form signed by the family on 04/17/14 which noted Resident #100 desired 3 showers per week or as requested. Review of the shower schedule, last updated 10/13/14, revealed Resident #100 was scheduled to receive 2 showers per week. Review of the shower documentation revealed showers were sporadically documented showing showers were given to Resident #100 1 to 5 times a week. In August she received showers 3 times per week until the week of August 24th when there were no showers documented; the week of August 31st per documentation she received 1 shower; 2 showers were documented	F 242	to this citation. Resident #100 received a shower 10/17/2014. 2. All residents have the potential to be affected by this citation. The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) interviewed residents and/or their responsible parties for shower preferences and get up times 11/18/2014-11/21/2014. 3. Certified Nurse Assistants, Licensed Nurses were in serviced by the Director of Clinical Services and/or Nursing Supervisor on providing showers per resident preference, providing bed baths on other days 11/10/2014-12/04/2014. Director of Clinical Services and/or Nursing Supervisor will perform audit of residents receiving showers and/or bed baths for honoring of preferences 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 1 month and 1 time a week for 1 month and/or substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of	

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F 242	Continued From page 10	F 242		

the week of September 7th; no showers were documented the weeks of September 14th or September 21st; and 2 showers were documented the week of September 28th and October 5th.

On 10/15/14 at 1:47 AM (a Wednesday), Resident #100 stated she was waiting on a shower. She explained that she had lots of urinary tract infections and was supposed to receive showers daily.

On 10/15/14 at 2:07 PM, Nurse Aide (NA) #4 stated Resident #100 used to get a shower every other day, Tuesdays, Thursdays, and Sundays, but now only gets a shower twice a week. She was unable to say why her showers were cut back to 2 per week or when.

On Thursday 10/16/14 at 10:00 AM, the resident told the surveyor she wanted a bath or she would have skin issues due to incontinence.

Interview with family on 10/16/14 at 11:21 AM revealed Resident #100 was always very particular about her hygiene and would like a shower every day. The family stated they thought she was getting a shower 3 times per week.

Interview with Nurse #4 on 10/17/14 at 11:12 AM revealed Resident #100 used to receive daily showers but that schedule got changed. She further stated that a resident would be showered extra upon request. Nurse #4 stated the Director of Nursing (DON) made up the shower schedule.

On 10/17/14 at 2:38 PM, the DON stated that upon admission, residents were asked about their bathing preferences and shower schedule. This

Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.

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F 242	Continued From page 11 was written on a form and given to the DON to place on the shower schedule. DON stated when he came to the facility, he never changed the schedule that Resident #100 was previously on and he was unaware that Resident #100 preferred more than 2 showers per week.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview and record review, the facility failed to ensure 1 of 1 sampled resident reviewed for accommodation of special physical needs was provided with a specially placed drinking device and long straw in order to access his own fluids. (Resident #61). The findings included: Resident #61 was admitted to the facility on 09/28/12 and most recently readmitted on 09/14/14. His diagnoses included quadriplegia, anxiety, and depression. His annual Minimum Data Set dated 09/21/14 coded him as having no cognitive impairments, having verbal behaviors 1 - 3 days in the previous	F 246	1. Resident #61 was not injured related to this citation. A drink aide with long straw was secured to resident #61 side rail on 10/21/2014 by the Maintenance Director. 2. Residents who have/need specially placed drinking devices have the potential to be affected by this citation. Observations for specialty drinking devices placed within reach was completed by the Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) on 11/17/2014-11/19/2014.	12/5/14

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 10/28/2014

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 246	Continued From page 12 7 days, requiring total assistance for all activities of daily living skills, including eating, and being nonambulatory. The Care Area Assessment for activities of daily living skills (ADLs) dated 09/30/14 noted he required total assistance with all ADLs due to quadriplegia. A care plan originally developed 05/24/13 and last updated 09/30/14 which addressed the problem of requiring total assistance for all ADLs included the interventions to keep the call light and personal items in reach at all times. A physician's order dated 10/12/14 included to "replace cup with long straw for pt (patient) to drink independently." Observations dated 10/13/14 at 4:57 PM revealed Resident #61 had a mouth/breath operated call bell system which he was able to activate independently. He was unable to lift his arms or move his hands. Resident #61's water pitcher and tea were located on the overbed table which was pushed up against the wall on 10/14/14 at 7:40 AM and at 7:57 AM. On 10/14/14 at 7:57 AM, Resident #61 stated he had a cup holder on his siderail (observed located on the right upper siderail) for his water to be accessible, however, it was no longer being used as it did not work properly. Water was on the overbed table which was pushed up against the wall on 10/14/14 at 9:09 AM, 10:27 AM, 11:50 PM, 12:27 PM, 12:56 PM, 2:52 PM, and at 4:48 PM; and on 10/15/14 at 10:40 AM. On 10/15/14 at 1:50 PM Nurse Aide (NA) #4 stated she did not know why the cup holder on	F 246	3. The Director of Nursing and/or Nursing Supervisor in serviced licensed nurses and certified nurse assistance on ensuring that specialty drinking devices like long drinking straws were within resident reach and to notify the Director of Clinical Services if missing 11/10/2014-12/4/2014. The Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) will perform Quality Improvement monitoring of 10 resident rooms for placement of special drinking devices IE long straws 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks, 1 time a week for 4 weeks and/or substantial compliance obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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

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F 246	Continued From page 13	F 246		

the siderail was not being used to keep the water accessible to Resident #61.

On 10/15/14 at 2:57 PM, Nurse #4 set up water in the cup holder that was attached to the siderail along with a long straw that could reach his mouth. She stated the cup holder needed to be tightened to the side rail. She stated that he used his call bell and asked staff to give him water to drink. She then stated she would have maintenance tighten the cup holder to the siderail so it stayed firmly in place and his water could be accessible to him. On 10/15/14 at 6:40 PM, water was in a cup in the cup holder located on the siderail. The cup held an extra long straw positioned where he could drink independently.

On 10/16/14 at 7:41 AM Resident #61 activated his call light because his water located in the cup holder on the siderail tipped over out of his reach. NA #1 who answered the call bell stated she would have maintenance look at the cup holder.

On 10/16/14 at 8:30 AM, the maintenance staff stated there was a new cup holder on order. The maintenance staff stated the cup the resident preferred to use was too heavy for the holder which was the reason the fasteners loosened up so quickly and his water tipped over out of his reach. He stated he again tightened the screw to keep the holder in place. Upon observation, the cup holder and water was tight and within the resident's reach and Resident #61 was observed independently drinking from the water using the extra long straw. On 10/16/14 at 10:09 AM Resident #61 stated he had staff move his water out of the way because it kept falling over and was out of his reach.

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 10/28/2014

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

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F 246	Continued From page 14 On 10/17/14 at 11:17 AM the water bottle in the cup holder on the siderail was tipped over causing the long straw to be out of the resident's reach. Resident #61 stated the holder fell over. On 10/21/14 at 4:30 PM, the maintenance staff provided evidence of a drink aide having been ordered for Resident #61 on 02/28/14. He stated a new holder was ordered that would stay in place. He was unable to obtain evidence that a new one was ordered since 02/28/14 to replace the one which was not staying in place and in reach of the resident.	F 246		
F 249 SS=B	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to ensure the activities programs were directed by a qualified	F 249	1. No resident was injured related to this citation. A Certified Activity Director was put into	12/5/14

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 10/28/2014

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 249	Continued From page 15 professional. The findings included: A review of a facility document titled List of Key Personnel provided by the Administrator on 10/12/14 at 3:58 PM indicated a staff name with the title of Director of Activities. Observations on 10/13/14 at 2:30 PM revealed the Director of Activities leading a group activity of popcorn and movies for residents. Observations on 10/14/14 at 3:47 PM revealed the Director of Activities leading a group activity of bingo in the main dining room for residents. Observations on 10/15/14 at 10:30 AM revealed the Director of Activities leading a group activity in the main dining room with coffee and donuts for residents. Observations on 10/20/14 at 2:00 PM revealed the Director of Activities in the main dining room setting up a popcorn machine for a group activity of popcorn and movies for residents. During an interview on 10/21/14 at 10:35 AM the Director of Activities verified that was her official job title and said she had served in that role since February 2014. She stated she was responsible for all of the facility activity programs and she created the monthly activity schedules. She explained from November 2013 until February 2014 there was no official activity director but she had kept activities going because her job title during that time was activity assistant. She stated she attended the monthly resident council meetings as the Director of Activities to find out	F 249	place on 11/13/2014. 2. All residents have the potential to be affected by this citation. The facility will maintain a Qualified Activity Professional as defined in the regulation as the Director. 3. The Executive Director was in serviced by the Regional Director of Clinical Services on ensuring that the Activity Director is certified 11/25/2014. The Executive Director will perform Quality Improvement Monitoring of the facility having a Certified Activity Director 1 time a month for 6 months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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

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F 249	Continued From page 16 what residents wanted to do during activity programs. She explained she had an activities assistant and other staff assisted with activities as needed. During a follow up interview on 10/21/14 at 11:17 AM the Director of Activities stated she was not licensed or certified as an activity director, did not have any official qualifications as the activity director and had not completed any approved training courses. She explained she had discussed training with the previous administrator but was told she would have to get the certification on her own and since she could not afford it she had not followed up on it since that conversation. During an interview on 10/21/14 at 12:25 PM the Administrator verified she was aware the Director of Activities was not a qualified activity director. She explained she knew the Director of Activities should be qualified and they had talked about it but they had not provided her with training in an approved training course because there were a lot of issues that had needed her immediate attention and it just had not been done.	F 249		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 250		12/5/14

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 10/28/2014

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 250	Continued From page 17 Based on record review, resident interviews, family interviews and staff interviews, the facility failed to re-evaluate and adjust interventions and care for 3 of 3 residents sampled for psychosocial well-being. Residents #61 and #100 did not receive changes in their care to effectively deal with behaviors and disruptive thought processes and Resident #58 did not receive information related to hospice services and clarification of her desires relating to future medical care. The findings included: 1. Resident #61 was admitted to the facility on 09/28/12 and most recently readmitted on 09/14/14. His diagnoses included quadriplegia, chronic pain, anxiety, and depression. Psychiatric medications included Wellbutrin XL (an antidepressant) 150 milligram (mg) Monday, Wednesday and Fridays ordered since 07/03/14, Valium (an antianxiety) 10 mg every 6 hours as needed ordered since 2013, Ativan (an antianxiety) 1 mg ordered since 2013. The behavior care plan was originally developed on 05/24/13 which identified the problem of his individual coping being ineffective related to behaviors. The resident was noted to be verbally abusive to staff at times. A non-dated handwritten addition to the problem noted that he sat in the hall or his room and yelled. The goal was to have a decrease in behaviors for no more than 2 documented episodes of behaviors per week. Interventions included: *monitor behaviors and document; *administer medications as ordered with 2 nurses present; *approach in calm reassuring manner;	F 250	1. Resident #61 was assessed by the physician on 11/18/2014 with no new orders. Residents care plan was reviewed and updated on 11/25/2014 by the Director of Clinical Services and/or Nursing Supervisor. Resident #100 was assessed by the physician on 11/18/2014 no new orders. Residents care plan was reviewed and updated on 11/25/2014 by the Director of Clinical Services and/or Nursing Supervisor. Resident #58 no longer resides at the facility.. 2. All residents have the potential to be affected by this citation. An audit of care plans of residents with behaviors was completed 11/24/2014-12/4/2014 by the Director of Nursing and/or Nursing supervisor. Residents with new and/or exacerbated behaviors will be reviewed in the morning clinical meeting with care plan revisions if needed. Code status of new residents will be discussed in the morning clinical meeting. Should a resident reach end of life and hospice is ordered or desired the Social Services Director will make contact with the Hospice Company. A current review of current residents advance directives, code status and physician progress note to ensure they match was completed by the Director of Social Services on 11/14/2014. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses on documentation of the effectiveness of as needed medication,	

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 10/28/2014

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 250	Continued From page 18 *provide a consistent daily routine; *don't argue with him; *remove him from public when behavior is disruptive; *praise him when demonstrating desired behavior; *reinforce with him the unacceptability of verbal abuse; *discuss with him past successful coping mechanisms (no specifics provided); and *requires frequent redirection about his call light due to him activating his call light before staff leave the room. The behavior care plan was updated on 11/19/13 with the intervention that when Resident #61 was upset, yelling and cursing, tell him "I know your (sic) upset right now. I'm going to walk away while you calm down et (and) I will be back in 10 mins (minutes)" then reapproach. Another addition to the interventions was dated 09/14/15 (sic ? year) that stated staff may close the resident's door if he yells and was belligerent to protect other residents that were sleeping. Nursing notes revealed Resident #61 yelled and cursed at the nurses on 04/03/14 and 04/12/14. The Licensed Clinical Social Worker (LCSW from an outside agency providing psychological services) was involved in his mental health. The notes through April 2014 noted the LCSW was working on cognitive behavior interventions, coping skills and being supportive. Per the notes, Resident #61 perceived that he was getting along better with staff. A quarterly Minimum Data Set (MDS) dated 04/29/14 coded him with intact cognition, exhibiting verbal behaviors 4-6 days in the	F 250	advance directives, updating care plans when needed related to behaviors, dealing with difficult behaviors, monitoring of resident behaviors using the Behavior monitoring form and notifying the physician for new or exacerbated behaviors 11/10/2014-12/4/2014.The Director of Clinical Services and/or Nursing Supervisor in serviced certified nurse assistants on dealing with residents with difficult behaviors and to report behaviors to the licensed nurse 11/10/2014-12/4/2014. The Director of Clinical Services and/or Nursing Supervisor, Social Services Director will perform Quality Improvement monitoring of 5 residents with behaviors medical records for psychological services monitoring, effectiveness of as needed medications and care plan to ensure interventions are in place and they are effective 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks and/or until substantial compliance obtained. Director of Clinical Services, Social Services Director and Executive Director will conduct Quality Improvement monitoring of 10 resident□s charts for advance directives for future health decisions with most current physician progress note 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for	

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 250	Continued From page 19	F 250		

previous 7 days, having other behaviors 4-6 days in the previous 7 days, and rejecting care 1-3 days in the previous 7 days. He was coded as requiring total assistance with all activities of daily living (ADLs) and having been seen in psychotherapy.

Social Worker (SW) progress review dated 04/29/14 noted that he was feeling or appearing down, depressed or hopeless, and had daily episodes of screaming at others and disruptive sounds. Interventions were noted for staff to redirect and educate resident. The note also stated Resident #61 continued to be angry with his functional status and inability to walk, he remained the same where medication management was involved.

LCSW note dated 05/19/14 noted he distrusted certain nurses. During this session the nurse checked on Resident #61 and addressed the behavior of him yelling out. The resident stated he would stop yelling if staff would check on him more. A note was written in this report that read "Note to staff: recommend a bi-hourly check in." It was unclear if this was verbally told to staff.

SW progress notes dated 06/16/14 revealed the resident's medications related to mood and behaviors were reviewed. No changes had been made and the LCSW was involved in his mental health. The note stated the resident continued to yell out, curse staff and be preoccupied with his bowels and catheter. The note stated "Resident is reminded by staff as needed that they are here to meet his needs. Resident is educated daily how to appropriately address staff. Although this (sic) behaviors continue daily, it is decreasing in frequency. Staff continue to provide empathetic

six months by the Director of Clinical Services 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.

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 10/28/2014

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 250	Continued From page 20	F 250		

listening." No changes were made in the behavioral care plan.

Review of nursing notes revealed behaviors as follows:
*07/04/14 during 11:00 PM-7:00 AM shift, resident began cursing and yelling at the nurse aides when they told him they had to check with the nurse before removing foot booties and his oxygen. Then at 10:00 PM the resident was noted with a belligerent attitude, screaming and cursing at staff. He demanded medicine immediately and refused to be turned and repositioned. He was medicated with Ativan and a requested suppository with good effect.
*07/05/14 at 3:30 PM resident was yelling and cursing. His door was shut per care plan for 15 minutes and upon reopening the door, he began cursing again and the door was shut for 10 more minutes. An hour later he was noted as yelling out and cursing repeatedly resulting in his door being shut again. Afterwards he was noted resting.
*07/07/14 at 1:45 PM resident continually yelling out for staff and wanting staff to stay in his room with him. Valium was given and he was later noted resting.

On 07/10/14 the physician's orders revealed his Ativan was reduced from 1 mg to 0.5 mg as needed.

Behaviors per nursing notes continued:
*07/11/14 at 11:00 PM resident noted constantly demanding more drugs, constant attention, and redirection was not effective.
*07/12/14 at 3:00 PM resident was yelling and cursing staff, accusing them of hurting him, and repeatedly asking for cigarettes then accusing

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 10/28/2014

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 250	Continued From page 21	F 250		

staff of taking them. During the 3:00 PM - 11:00 PM shift, resident noted to continue to curse staff and call them names throughout the shift. *07/13/14 at 6:00 PM and 9:00 PM behaviors of cursing staff, name calling and/or accusing staff of not providing care and poisoning him.

Nursing notes dated 07/17/14 stated an interdisciplinary meeting was held due to the resident constantly using the call bell. Concerns and issues were addressed then he would activate his call light again to discuss the same issues. The note stated an action plan was to be developed over the next several days focusing facility actions on the resident's concerns. No changes were made to the care plan.

Behaviors of cursing, yelling, calling staff names and demanding medications continued to be documented on 07/17/14 at 10:16 PM; 07/19/14 at 2:00 PM, and 11:00 PM; 07/20/14 at 11:00 PM; 07/21/14 at 11:00 PM; 07/28/14 at 7:05 PM he was noted asleep after door was shut for 10 minutes; 07/29/14 at 8:14 PM and 9:10 PM; and on 07/30/14 at 5:15 PM.

SW progress review dated 07/31/14 noted he was feeling depressed regarding his physical status and he yelled and cursed at staff and refused care. Staff educated the resident and attempted redirection and provided empathetic listening. Resident #61 was noted as still seeing the LCSW. This note stated there was a tentative discharge plan for the resident to return to the community to live with family. No changes were made to the behavior care plan but changes were made monthly to the care plan relative to his constipation and bowel complaints. .

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 10/28/2014

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 250	Continued From page 22	F 250		

Nursing notes dated 07/31/14 at 1:10 PM revealed an interdisciplinary meeting met to review his behaviors. It was noted his behaviors continued daily with resident yelling, demanding and cursing staff, requesting multiple medications or to be sent to the hospital. The note stated that staff have been educated that when the resident was inappropriate they could tell him that they were going to walk away and give him time to calm down. The note stated the director of clinical services was to research for more appropriate activities and continue to monitor behaviors.

Behaviors continued to be documented including cursing and/or threatening staff on 08/03/14 at 1:50 PM and 5:05 PM resulting in other residents complaining about his cursing; on 08/07/14 at 6:30 PM and 10:15 PM; and on 08/11/14 at 11:00 PM one on one care provided with little effect noted.

LCSW notes dated 08/11/14 recommended the additional medication of Klonopin (an antianxiety medication) 0.5 mg at bedtime and Lexapro (an antidepressant medication) 10 mg daily. These were started on 08/14/14.

Nursing notes dated 08/14/14 (no time) stated an interdisciplinary meeting was held to review behaviors which remained unchanged with the plan to continue to monitor. No changes were made to the behavior care plan.

LCSW notes dated 08/25/14 noted that staff reported Resident #61 got along better with the day staff than night staff. The LCSW note revealed he worked on deep breathing and relaxation techniques.

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 10/28/2014

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 250	Continued From page 23	F 250		

On 08/30/14 at 3:00 PM nursing notes revealed the resident was yelling and calling staff names which was noted to upset another resident. Redirection was ineffective.

Nursing notes dated 09/04/14 at 1:30 PM stated an interdisciplinary meeting was held and reviewed his chart for behaviors. Staff had requested assistance with technology devices from an outside agency to help decrease behavior outbursts by diverting his attention. No changes were made to the behavior care plan.

Resident #61 was hospitalized from 09/08/14 and readmitted to the facility on 09/14/14 from an upper gastrointestinal bleed and infection. Readmission medications included Ativan 1 mg and Valium 10 mg as needed, and Wellbutrin 3 days per week.

On 09/14/14 the resident was noted screaming from 9:00 PM to 11:00 PM, cursing at the staff, demanding a suppository, resulting in another resident complaining. Nursing notes dated 09/17/14 during 3:00 PM-11:00 PM shift noted screaming and cursing which resulted in other residents complaining.

Review of the LCSW notes dated 09/15/14 and 09/29/14 indicated medication recommendation included Ativan 0.5 mg every 4 hours as needed, Lexapro 10 mg daily and Klonopin 0.5 mg at night. He also checked that medication appeared to be effectively managing symptoms and recommended they be maintained. No changes were made in the medications regime.

SW progress review dated 09/21/14 noted

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 10/28/2014

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 250	Continued From page 24	F 250		

Resident #61 continued to yell at and curse staff several days a week with multiple requests for enemas and suppositories daily. Staff provided redirection and encouragement as needed, assuring resident that staff was there to meet his needs and provided empathetic listening. This note stated that discharge plans were no longer a viable alternative due to resident safety. No changes were made to the behavior care plan.

His annual MDS dated 09/21/14 coded him as having no cognitive impairments, having verbal behaviors 1 - 3 days in the previous 7 days, requiring total assistance for all activities of daily living skills, being nonambulatory, receiving psychiatric therapy and psychiatric medications.

The behavior Care Area Assessment (CAA) dated 09/30/14, which also incorporated the cognition and psychosocial well-being CAAs, identified the complications and risk factors as "individual coping, ineffective related to behaviors." There was no additional information analyzing what his behaviors were, what triggered them, or what response was effective in decreasing his behaviors.

Nursing notes dated 09/30/14 at 9:00 PM revealed he had some yelling and cursing which calmed with 1 on 1 interaction. Nursing notes dated 10/02/14 at 1:00 PM stated an interdisciplinary team met and reviewed Resident #61's behaviors. Resident was noted to continue to ring call light frequently and yell out requesting more medications. Redirection was provided and the facility was in the process of providing a computer so resident will have access to increased activities per his request. No changes were made to the behavior plan of care.

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 10/28/2014

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 250	Continued From page 25	F 250		

Nursing notes dated 10/12/14 at 8:00 AM revealed Resident #61 was yelling and cursing repeatedly for no reason.

On 10/14/14 at 11:37 AM, interview with Nurse Aide (NA) #4, who normally worked with Resident #61 on the first shift stated he had good and bad days. She described him as not believing what staff tell him resulting in 2 nurses having to give him his medications. She stated he would activate his call bell then immediately start yelling for help. She stated that his behaviors often centered around his concerns regarding his bowels and need for more medications for them. On follow up interview on 10/14/14 at 11:48 AM, NA #4 stated he was sometimes impossible to take care of and he has refused to be cared for by several people. When asked how she had been trained to handle his behaviors, she stated that she normally got the Director of Nursing (DON) who seemed to be able to better manage him. She stated that Resident #61's behaviors of cursing and yelling bothered other residents on the hall and staff tried to redirect him.

Nursing notes dated 10/14/14 at 10:00 PM stated staff was frequently in the resident's room answering his call light and the resident was yelling at and threatening staff when staff was not immediately responsive. He was noted to be fixated on his bowels. One on one care provided as needed to help decrease his level of anxiety which was slightly effective.

Review of the LCSW notes revealed the LCSW usually visited with Resident #61 approximately every 2 weeks. These notes indicated the psychotropic medications were effective.

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 10/28/2014

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 250	Continued From page 26	F 250		

Interview with the LCSW on 10/15/14 at 2:47 PM revealed normally staff told him the recent problems and that was what the LCSW would address with the resident. He further stated Resident #61 felt staff left him unattended for long periods of time. LCSW stated his only recommendation that he thought he made to the facility staff to deal with his behaviors was to check in with him at designated times, such as every 30 minutes, to make him feel better so he would know the staff were present. He stated he thought he wrote that plan in his notes, although review of notes did not address such a plan. He stated he spoke with the resident about treating others nicely. He stated that he had not met with the facility staff to develop any type of behavior management plan or any other formalized plan for all staff to consistently address and deal with the resident's ongoing behaviors. He stated the facility had not discussed any development of a plan with the LCSW but that he could work on a plan next week. Review of his notes revealed, LCSW made no changes to the psychiatric medications

Interview on 10/15/14 at 4:55 PM with NA #6 revealed she normally worked second shift. She stated that she was able to tolerate the resident better than other staff and has been moved to his hall. She stated the care guide instructed staff to walk away from him when he became belligerent but that in her opinion, walking away just made him more mad as he just shouted and threatened to take her job away, which she said happened often. She stated she had not received any instructions on specific behavior techniques to use for him. She further stated that when his family visited his behaviors improved.

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 10/28/2014

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 250	Continued From page 27	F 250		

Nursing notes dated 10/15/14 at 10:45 PM revealed this resident was verbally abusive most of the 3:00 PM-11:00 PM shift. Staff were in the resident's room approximately every 15 - 30 minutes. After care was completed, the resident would activate his call light within 2-3 minutes. He was noted cursing, yelling and making threats even with one on one for most of the shift. The note revealed residents in the surrounding rooms were awakened by Resident #61.

Nurse #5, who worked the 11:00 PM-7:00 AM shift was interviewed on 10/16/14 at 6:56 AM. She stated that his complaints with her, tended to center around medication and times of medication administration. She stated when he cursed or yelled she walked out of the room and told him she did not set up the medications or the times. She further stated that he enjoyed attention.

On 10/16/14 at 7:05 AM NA #7 stated that during the night if Resident #61 exhibited behaviors, staff tried to talk to him and calm him down. She further stated he did not have many behaviors during the night shift.

On 10/16/14 at 8:30 AM and 10:09 AM Resident #61 complained to the surveyor about the manner in which staff treated him. He stated the nurses did not give him his medications in the correct dosage or at the correct times and that they decided when he received his as needed medications. He also stated that he was claustrophobic and did not like the door to his room being shut.

On 10/16/14 at 10:59 AM the DON stated that they were trying to find Resident #61 something

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 10/28/2014

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 250	Continued From page 28	F 250		

technology wise to occupy more of his time. When asked how he expected staff to deal with Resident #61's outbursts of yelling and cursing, he stated he instructed staff to put themselves in the resident's shoes and empathize with him.

On 10/16/14 at 4:46 PM SW stated the interdisciplinary team met to review behaviors and assist in developing care plans. Regarding Resident #61, staff were expected to handle him with respect and the DON had instructed staff to be particularly empathetic with his condition. At this time the DON joined the conversation and he and SW stated neither had met with the psychological service (LCSW) who met with Resident #61 every 2 weeks to develop any type of behavior plan to ensure staff are handling the behaviors consistently. The DON stated he tried to meet with the resident and remind him the facility will work out his concerns. DON further stated that when his roommate had one on one care, Resident #61 really enjoyed the attention he also received.

On 10/16/14 at 5:11 PM interview with Nurse #13 revealed Resident #61 often made claims against staff relating to them not giving him water, food, medications, etc. The plan included that staff always took another staff member into the room so there was a witness to the accusations.

On 10/16/14 at 10:30 PM nursing notes stated the resident yelled the entire 3:00 PM-11:00 PM shift. He became easily angered. He was requesting one on one care and if he did not receive, he screamed and cursed and threatened staff. Redirection was not effective. On 10/17/14 during the 11:00 PM-7:00 AM shift he was requesting care every 5 to 10 minutes and was

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 10/28/2014

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 250	Continued From page 29	F 250		

speaking loudly enough to awaken another resident who complained.

On 10/17/14 at 11:17 AM Resident #61 offered the surveyor more complaints about staff "picking on him" and staff telling him he disturbed other residents last night.

ON 10/17/14 at 12:08 PM Nurse #4 stated during another interview that she had no problems with Resident #61 but he seemed more irritable in the evenings. She stated she has found him easy to redirect. In terms of what has been established as a plan to deal with his behaviors, Nurse #4 stated they have been told that the staff can walk out on him when he is cursing and return in a few minutes. She further stated that Resident #61 disliked having the door or curtain closed as he complained he was claustrophobic. Nurse #4 instructed her staff to stay calm and get her when he was exhibiting behaviors. She stated some staff got very frustrated with the way he treated them.

Interview with the MDS Coordinator on 10/17/14 at 12:37 PM revealed the behavior care plans were developed as a team. She stated there had never been a behavior modification plan developed in order for all staff to be consistent when he exhibits disruptive behaviors. The current plan was to get him a computer.

Review of the resident's medication administration record from 10/01/14 through 10/19/14 revealed Valium was administered 48 times and it was documented to be effective 10 times and Ativan was administered 50 times and it was documented to be effective 12 times. Most of the entries failed to document any

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 10/28/2014

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 250	Continued From page 30	F 250		

effectiveness.

On 10/20/14 at 2:53 PM, DON stated staff had daily rounds to check with Resident #61 in order to meet his needs and diffuse behaviors. DON shared these forms on 10/21/14 at 8:45 AM completed on Resident #61 named "Adopt -A-Resident-Quality Assurance." The specifics to be monitored for Resident #61 on this form included to ease his fear of being alone/dying and to address behaviors. Instructions included: 1. reassure resident that staff was there for him and allow resident to talk about his fears. Redirect the conversation to something positive; and 2. When resident yells or curses don't react other than to tell him you'll allow him a few minutes to calm down then come back. Always remain calm and try to redirect. Keep conversations positive when possible. This form provided a place for comments on all three shifts with places for nurses and nurse aides to sign. Review of the forms provided since 05/19/14 revealed no changes in approaches had been made and most forms were blank in terms of progress or the form just noted his needs were met. DON stated that sometimes his behavior was okay and other times he was not re-directable. DON stated that it was the facility's hope that getting him a computer would help diminish his behaviors and that the agency was due to come to the facility and assess the resident the following week.

On 10/21/14 at 9:07 AM Resident #61's physician stated that there was no specific behavior plan, interventions have happened "piece meal." The physician stated he saw him often, often without writing a note because the resident enjoyed seeing the doctor. The last time the physician recalled meeting with the DON and family 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 10/28/2014

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 250	Continued From page 31	F 250		

resident was when Resident #61 was talking about going home. The physician further stated that he had found the LCSW was better at counseling residents than medication management.

2. Resident #100 was admitted to the facility on 04/17/14 following a psychiatric hospitalization that began on 04/10/14 for exacerbation of behavioral disturbance. Her diagnoses included Parkinson's disease, history of traumatic brain injury, and dementia.

The admission Minimum Data Set (MDS) dated 04/24/14 coded her with usually being understood and usually understanding, having some inattention and disorganized thinking, having moderately impaired cognition (scoring a 10 out of 15 on the brief interview for mental status), receiving antipsychotic medication in the previous 7 days and having no behaviors in the previous 7 days.

A physician's progress note dated 05/19/14 stated that following her hospitalization and following relative stabilization, Resident #100 was transferred to this facility for ongoing management and rehabilitation. The physician noted the plan was he "assessed the course of this patient's dementia, and the patient demonstrates instability requiring significant support and frequent monitoring. The risk of other complications of dementia persists. We will continue to provide support and preventative measures for this patient and remain vigilant for changes in condition."

A physician's progress note dated 05/22/14 noted Resident #100 was having behavioral changes

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 10/28/2014

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 250	Continued From page 32	F 250		

and confusion and emotional liability. On 05/26/14 laboratory testing was ordered for a urinalysis and potassium, and Remeron, an antidepressant, was started.

Review of physician orders revealed an undated written order (between physician orders dated 05/21/14 and 05/26/14) for a psychiatric consult for stabilization of disorganized thinking. Per interview on 10/15/14 at 3:10 PM, the facility Social Worker (SW) stated that the facility utilized an outside psychological service agency to provide in facility therapy treatment. This person was a licensed clinical social worker (LCSW).

A LCSW assessed Resident #100 for staff reports of increased anxiety and periods of depression on 05/27/14. This assessment noted that she had mood swings from happy to sad, had trouble getting to sleep, waking up and having a low appetite. The social worker noted she had a history of panic attacks. This evaluation noted that the review of her medications including Remeron (an antidepressant), Xanax (an antianxiety) and Depakote (a mood stabilizer) were appropriate. The plan was to follow up with psychotherapy in 2 weeks. There was no evidence of any follow up visit.

A nurses note dated 05/27/14 at 7:40 PM stated the resident was sent to the hospital for a psychiatric evaluation due to throwing bottles and cups across the room at her roommate. She was admitted and returned to the facility on 06/01/14.

On 06/09/14 she began an antibiotic for 10 days for a urinary tract infection. On 06/16/14 at 2:00 PM a nursing note revealed she was alert with

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 10/28/2014

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 250	Continued From page 33	F 250		

confusion, receiving an antibiotic, was making negative statements such as "not wanting to live like this." She later stated she was just reliving her car wreck. On 06/16/14 at 2:15 PM nursing notes stated she was at the nurses station with the nurse on 1 to 1 monitoring. She stated that she was reliving her car wreck and it was horrible and if she did not get help she would take her own life. She was transferred to the hospital and admitted for services. She returned to the facility on 06/17/14.

On 08/10/14 she began an antibiotic for 7 days for a urinary tract infection. Nursing notes dated 08/16/14 at 10:00 AM revealed Resident #100 was anxious and stated she did not want to live with handicapped people as it made her feel crazy. She further stated she wanted to go to jail and be left alone. The note further stated she had slung the tray on the floor at breakfast and was yelling at staff.

Nursing notes dated 08/17/14 at 4:00 AM revealed she asked the nurse aide to call 911 as she wanted to go back to the local psychiatric hospital. She was stating she hated staff and was clenching her fists. She calmed down after being told the time of day.

On 09/17/14 a telephone order was written for a psychiatric consult for depression. This was taken by the unit manager/treatment nurse and signed by the physician on 09/18/14. In addition, Resident #100 was started on an antibiotic for 7 days on 09/18/14 for a urinary tract infection.

A nursing note dated 10/09/14 at 1:00 PM stated the interdisciplinary team met and reviewed Resident #100's behaviors. She was noted to

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 10/28/2014

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 250	Continued From page 34	F 250		

have no agitation noted for 2 days and that agitation and increased behaviors were noted in days prior. The note stated the facility would continue to monitor the current plan of care. Nothing was noted about the lack of psychiatric visits or the psychiatric consult which was ordered 09/17/14.

On 10/10/14 Resident #100 was started on an antibiotic for 7 days for a urinary tract infection. The antibiotic was changed on 10/14/14 due to sensitivity results to another antibiotic for 7 days. On 10/14/14 at 8:48 AM, Nurse #4 stated that Resident #100 was being sent out to the hospital this date to be checked out psychologically. She further explained that every so often the resident was triggered into thinking about her car wreck as a teenager, which caused a traumatic brain injury and she would request to be sent to the hospital. This was happening this date. Nurse #4 stated when she requests to be sent out, we just send her out. The resident returned to the facility later this same date.

A social note dated 10/14/14 stated that staff informed her that Resident #100 was having suicidal ideations. The SW's note stated the resident she could not remember saying it but that she felt like she was losing it and needed a psychological exam. The note also indicated the LCSW was notified as she was under his care for psychological visits. There was no evidence that the LCSW ever returned to visit Resident #100 after his initial visit of 05/27/14 or following the psychiatric consult order dated 09/17/14. Interview with the LCSW on 10/15/14 at 2:44 PM revealed he was responsible for scheduling his own follow up visit but that he just failed to follow up with her which was his intended plan. He

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 10/28/2014

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 250	Continued From page 35	F 250		

stated he saw her today after the facility social worker called him following Resident #100's trip to the emergency room yesterday. He could not explain why he did not see her after the physician ordered psychiatric consult dated 09/17/14. He stated he may not have received the order.

On 10/15/14 at 3:10 PM, the Social Worker (SW) stated that when there was an order for a psychiatric consult, she was responsible for calling the LCSW to see the resident. She stated the consult on 05/27/14 was because the resident had some issues before being admitted to this facility. She could not recall what happened or why Resident #100 was not seen following the order dated 09/17/14. She reviewed her notes and stated she could not recall if she was aware of the 09/17/14 order.

Interview with the resident's physician on 10/21/14 at 9:07 AM revealed he expected Resident #100 to be seen regularly by the LCSW.

3. Resident #58 was admitted to the facility on 09/03/14 with diagnoses including chronic respiratory failure, debility, chronic pain, osteoporosis, and anxiety.

The Medical Orders for Scope of Treatment (MOST) form dated 09/03/14 checked that Resident #58 decided she did not want to be resuscitated and only wanted limited additional interventions including transfer to the hospital if indicated. This form indicated that the MOST form was discussed and agreed to by the legal guardian of the resident. Review of the medical record revealed Resident #58 had no legal guardian but a durable power of attorney. On 10/17/14 at 8:42 AM the Admissions Coordinator

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 10/28/2014

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

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F 250	Continued From page 36	F 250		

stated he completed this form with the family on the day of admission. He stated he reviewed the form line by line and checked the decision based on what he was told by the family.

According to the physician's history and physical dated 09/04/14 she had end stage chronic obstructive pulmonary disease (COPD) and the resident decided to transfer to the facility instead of having hospice at home. The note continued that Resident #58 desired no more transfers to the hospital with a focus on symptom relief and comfort in the facility which she expressed to the hospital before being admitted to the facility. Resident #58 agreed to the plan that the facility would provide support, symptom management, and treatment, including antibiotics if deemed necessary for comfort. Under the plan the physician noted the resident demonstrated signs or symptoms consistent with end-of-life status or imminent death. The note continued to state the resident and or responsible party had chosen to forgo aggressive, heroic, curative, or life-sustaining measures, and instead focus on comfort care and quality of life.

Per the physician's progress note dated 09/09/14 Resident #58 was "hospice-appropriate and patient and family are amenable to this, as they identify hospice services as helpful with symptom and pain management. Discussed with staff regarding appropriate timing of hospice services in order to avoid financial hardship on family". The physician was interviewed on 10/21/14 at 9:07 AM. The physician stated that family was under the impression at admission that they would have to pay out of pocket if hospice services were provided in the facility. The physician stated that if the MOST form and his

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 10/28/2014

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

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F 250	Continued From page 37	F 250		

discussions with the resident and or family did not match, the issue of end of life expectations and desires needed to be revisited. The physician stated he talked to the DON, after his 09/09/14 visit about making sure the finances were clarified with the family so they could make a decision about hospice services.

Resident #58's admission Minimum Data Set dated 09/12/14 coded her with no cognitive impairments.

An interview was conducted on 10/14/14 at 9:15 AM with Resident #58's family (who held durable power of attorney (DPOA) for health care decisions) in the presence of the resident. The DPOA stated that the resident's regular physician had suggested hospice services. When she told the facility that before or on admission to the facility, she was informed that the facility's physician was trained in hospice services and could provide pain management. She stated that no one in the facility had discussed with them the pros or cons of hospice services or any financial aspects involved. During this interview, Resident #58 did not engage in the conversation and deferred to the DPOA. .

On 10/16/14 at 4:33 PM the Social Worker (SW) was interviewed. She stated that the MOST form and the physician orders for no resuscitation were obtained by the admission department upon admission. If there was a change in a resident's wishes it was up to the SW to address the change and change the forms. She stated she did not know about the resident's desire to not be hospitalized or that she was hospice appropriate or the physician wanted financial issues reviewed with the family. She stated she never spoke to the

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 10/28/2014

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

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F 250	Continued From page 38 family about hospice services but had heard from someone (she could not recall who but thought it was a nurse) that the family decided against hospice services. On 10/17/14 at 8:42 AM the Admission Director stated that upon admission, he had not discussed hospice with the family prior to admission. The DPOA approached him about pain management but never mentioned wanting hospice services to him. He further stated that that Resident #58 was a recipient of both Medicare and Medicaid so there would be no financial hardship to the resident should hospice services be initiated. On 10/20/14 at 2:46 PM the Director of Nursing (DON) stated he had not discussed hospice with the resident or the family. When told that the physician said he spoke to the DON about the family desiring hospice, DON did not have any comments. On 10/21/14 at 11:30 AM the DON stated the family had been in controversy regarding whether they wanted hospice or not.	F 250		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews the facility failed to provide hot water for showers in 2 of 3 shower rooms, failed to remove a broken bed out of a resident room for 1 of 4 halls, failed to repair	F 253	1. No residents were injured related to this citation. The Maintenance Director increased the temperature to the boiler on 10/15/2014. Combustion and Control Solutions INC	12/5/14

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 10/28/2014

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

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F 253	Continued From page 39 resident doors with splintered wood or broken laminate on 2 of 3 halls, failed to label and store bedpans off the bathroom floor on 2 of 3 halls, failed to repair stains on the bathroom floor and address odors in a resident bathroom on 1 of 3 halls, failed to replace a toilet tank lid in a resident's bathroom that did not fit on 1 of 3 halls, failed to maintain cleanliness of resident rooms for 1 of 4 halls and failed to provide paper towels and toilet tissue in resident bathrooms for 1 of 4 halls. The findings included: 1. Review of the temperature logs for the 2 shower rooms on the 200 hall dated 01/01/14 thru 10/11/14 revealed water temps to be between 99 to 112 degrees Fahrenheit (F) with the majority being between 107 to 108 degrees F. An observation was made on 10/15/14 at 10:02 AM with the Maintenance Director as he checked the water temperature in Shower Room #2 after a resident had been given a shower. The water temperature from the shower was 97.5 degrees F and 103.8 degrees F from the sink. The Maintenance Director stated he always checked the water temps in the shower rooms at the sinks and not the shower because they run off the same line. He further stated the water was colder at that time of day due to the laundry and dishwashing machines being used. He stated he had told staff in the past to wait until later in the day to give showers. An observation was made on 10/15/14 at 2:30 PM of Nurse Aide (NA) #2 and the Medical Records Coordinator taking a resident into Shower Room #2. Surveyor went into shower room with the resident and NAs to check the water temperature. The water temperature from the shower head was cold and did not warm up after running for a while. The shower was not	F 253	serviced the boiler on 10/28/2014. The Maintenance Director and/or Housekeeping Supervisor removed the non working bed in room 202A on 10/21/2014. Room 302 door was repaired 12/5/2014 by the Maintenance Director. Room 305 door was repaired 12/4/2014 by the Maintenance Director. Room 307 door was repaired 12/4/2014 by the Maintenance Director. Room 309 door was repaired 1245/2014 by the Maintenance Director. Room 310 door was repaired 12/4/2014 by the Maintenance Director. Room 313 door was repaired 12/4/2014 by the Maintenance Director. Room 206 door was repaired 12/4/2014 the Maintenance Director. Room 208 door was repaired 12/4/2014 by the Maintenance Director. Room 210 door was repaired 12/4/2014 by the Maintenance Director. Room 212 door was repaired 12/4/2014 by the Maintenance Director. Room 213 door was repaired 12/4 /2014 by the Maintenance Director. Bed pan in bathroom of room 301 was removed on 10/15/2014 by certified nurse aide. Bed pan in bathroom of room 213 was removed on 10/15/2014 by certified nurse aide. Room 213□s bathroom toilet tank lid was replaced on 10/22/2014 by the Maintenance Director. The floor in 213□s bathroom was cleaned on 10/23/2014 Resident #68 room 312, the floor was cleaned 10/14/2014 by housekeeping and	

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

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 253	Continued From page 40 given to the resident due to the water being too cold. An observation made on 10/15/14 at 3:06 PM with the Maintenance Director revealed the water temperature from the shower head in Shower Room #2 was 91.6 degrees F and 90.2 degrees F in Shower Room #1. The Maintenance Director stated he was going to talk with Administration about turning up the boiler to warm up the water. An observation made on 10/15/14 at 4:27 PM with the Maintenance Director revealed the water temperature from the shower head in the Shower Room #2 was 109 degrees F. The Maintenance Director stated he had turned up the boiler temperature to 166 degrees F and the water should stay warm in the showers all day. An interview was conducted on 10/14/14 at 7:49 AM with the Maintenance Director. He stated he checked water temperature in the shower rooms early in the mornings because he couldn't check the temperatures while the showers were in use. He stated he had received complaints from the staff about the shower water being too cold but he was told he had to keep the boiler set at 112 degrees F by Administration due to Life Safety codes. An interview was conducted on 10/15/14 at 2:43 PM with NA #4. She stated residents complained on a daily basis that the shower water was too cold. She stated she had reported the complaints to the nurses and housekeeping but was told the boiler could not be turned up. She further stated she thought the water was too cold for showers. An interview was conducted on 10/16/14 at 2:45 PM with the Director of Nursing. He stated he was not aware the water in Shower Rooms 1 and 2 had not been getting warm and that 91.6 degrees F was too cold for a resident shower. He further stated he was not aware that the	F 253	toilet paper and paper towels were supplied to bathroom by the activities assistant on 10/13/2014. Resident #1 room 314, the floor was cleaned on 10/17/2014 by housekeeping. 2. All residents have the potential to be affected by this citation. An audit of shower and faucet temperatures was completed by the Maintenance Director 11/17/2014-11/20/2014. Observations of toilet tank lids was completed by the Maintenance Director 11/17/2014-11/20/2014. Observation of cleanliness of residents rooms and rest rooms was completed by the Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) 11/17/2014-11/21/2014. Observation of for paper towels and toilet paper availability in restrooms was completed by Housekeeping Supervisor 11/17/2014-11/21/2014. Observations of resident doors and beds for function was completed by the Maintenance Director 11/17/2014-11/21/2014. 3. The Maintenance Director was in serviced by the Executive Director on making sure that the temperature in faucets and showers are maintained, that broken beds are to be removed from facility, broken laminate or splintered wood on doors are to be repaired, toilet tank lids are to fit toilets 11/20/2014.	

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 10/28/2014

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

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F 253	Continued From page 41 Maintenance Director had been told the boiler could not be set higher than 112 degrees F. He stated it was his expectation for residents to receive warm showers or baths. 2. An observation was made on 10/21/14 at 10:37 AM of unoccupied room 202 bed A. Bed A was in the low position and the foot of the bed was higher than the head of the bed, the controls for the bed would not lower the foot of the bed. An interview was conducted on 10/20/14 at 2:29 PM with Nurse #4. She stated there were no broken beds on the 200 hall. She further stated if furniture or equipment needed to be repaired she told the Maintenance Director or sent him a work order. A tour of the facility was conducted with the Maintenance Director on 10/21/14 at 3:00 PM. He stated he was not aware of any broken beds in the facility and the nurses called him or sent him a work order when an item needed to be repaired. The Maintenance Director tried to lower the foot of the bed in room 202, bed A, and it would not lower. He stated he was not aware the bed was broken and it should not have been in a room due to residents wandering into rooms and lying on the beds. He stated the bed should have been taken out of use until it had been repaired. An interview was conducted on 10/22/14 at 8:30 AM with the Director of Nursing (DON). He stated it was his expectation for all beds in resident rooms to work properly. He stated if equipment did not work the Maintenance Director should be informed via work order, face to face or telephone call. 3. a. Observations of Room 302 during the initial tour of the facility on 10/12/14 at 12:08 PM revealed the door of the resident's room had	F 253	House keeping was in serviced by the Executive Director on maintaining clean and odor free resident rooms and bathrooms, and the distribution of toilet paper and paper towels 11/20/2014-11/21/2014. Licensed Nurses and Certified Nurse Assistance were in serviced by the Director of Clinical Services and/or Nursing Supervisor on the proper storage of bed pans, wash basins and urinals 11/10/2014-12/05/2014. The Maintenance Director, Housekeeping Supervisor and/or Executive Director will perform Quality Improvement monitoring of 10 resident rooms for cleanliness 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks and 1 time a week for 4 weeks and/or substantial compliance is obtained. Maintenance Director and/or Executive Director will perform Quality Improvement monitoring of 10 resident rooms doors splintered wood and/or broken laminate 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks and 1 time a week for 4 weeks and/or substantial compliance is obtained. Maintenance Director and/or Executive Director will perform Quality Improvement monitoring of 10 resident bathrooms toilet tank for proper fit 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks and 1 time a week for 4 weeks and/or substantial compliance is obtained. Maintenance Director and/or Executive Director will perform Quality Improvement monitoring of 10 resident room/bathroom	

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 10/28/2014

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

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F 253	Continued From page 42 chipped wood with splinters and the laminate was broken on the bottom half of the front of the door. Observation on 10/13/14 at 2:50 PM the door of the resident's room 302 had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door. Observation on 10/14/14 at 3:30 PM the door of the resident's room 302 had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door. Observation on 10/21/14 at 2:42 PM the door of the resident's room 302 had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door. b. Observations of Room 305 during the initial tour of the facility on 10/12/14 at 12:08 PM revealed the door of the resident's room had a large triangular piece of laminate broken off. The remaining laminate was peeled back with jagged edges on the bottom half of the front of the door. Observation on 10/13/14 at 2:50 PM the door of the resident's room 305 had a large triangular piece of laminate broken off. The remaining laminate was peeled back with jagged edges on the bottom half of the front of the door. Observation on 10/14/14 at 3:30 PM the door of the resident's room 305 had a large triangular piece of laminate broken off. The remaining laminate was peeled back with jagged edges on the bottom half of the front of the door Observation on 10/21/14 at 2:42 PM the door of the resident's room 305 had a large triangular piece of laminate broken off. The remaining laminate was peeled back with jagged edges on the bottom half of the front of the door. c. Observations of Room 307 during the initial tour of the facility on 10/12/14 at 12:08 PM	F 253	faucets and 1 shower room for temperature between 100 degrees-116 degrees 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks and 1 time a week for 4 weeks and/or substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of 10 resident bathrooms for proper stored bed pans and basins 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks and 1 time a week for 4 weeks and/or substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Maintenance Director for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 253	Continued From page 43	F 253		

revealed the door of the resident's room had broken laminate with edges peeled back with jagged edges on the bottom half of the front of the door.
Observation on 10/13/14 at 2:50 PM the door of the resident's room 307 had broken laminate with edges peeled back with jagged edges on the bottom half of the front of the door.
Observation on 10/14/14 at 3:30 PM the door of the resident's room 307 had broken laminate with edges peeled back with jagged edges on the bottom half of the front of the door.
Observation on 10/21/14 at 2:42 PM the door of the resident's room 307 had broken laminate with edges peeled back with jagged edges on the bottom half of the front of the door.

d. Observations of Room 309 during the initial tour of the facility on 10/12/14 at 12:08 PM revealed the door of the resident's room had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/13/14 at 2:50 PM the door of the resident's room 309 had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/14/14 at 3:30 PM the door of the resident's room 309 had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/21/14 at 2:42 PM the door of the resident's room 309 had wood that was chipped and splintered on the bottom half of the front of the door.

e. Observations of Room 310 during the initial tour of the facility on 10/12/14 at 12:08 PM revealed the door of the resident's room had wood that was chipped and splintered on the

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 253	Continued From page 44 bottom half of the front of the door. Observation on 10/13/14 at 2:50 PM the door of the resident's room 310 had wood that was chipped and splintered on the bottom half of the front of the door. Observation on 10/14/14 at 3:30 PM the door of the resident's room 310 had wood that was chipped and splintered on the bottom half of the front of the door. Observation on 10/21/14 at 2:42 PM the door of the resident's room 310 had wood that was chipped and splintered on the bottom half of the front of the door. f. Observations of Room 313 during the initial tour of the facility on 10/12/14 at 12:08 PM revealed the door of the resident's room had wood that was chipped and splintered on the bottom half of the front of the door. Observation on 10/13/14 at 2:50 PM the door of the resident's room 313 had wood that was chipped and splintered on the bottom half of the front of the door. Observation on 10/14/14 at 3:30 PM the door of the resident's room 313 had wood that was chipped and splintered on the bottom half of the front of the door. Observation on 10/21/14 at 2:42 PM the door of the resident's room 313 had wood that was chipped and splintered on the bottom half of the front of the door. g. Observations of Room 206 during the initial tour of the facility on 10/12/14 at 12:08 PM revealed the door of the resident's room had wood that was chipped and splintered on the bottom half of the front of the door. Observation on 10/13/14 at 2:50 PM the door of the resident's room 206 had wood that was	F 253		

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 253	Continued From page 45	F 253		

chipped and splintered on the bottom half of the front of the door.
Observation on 10/14/14 at 3:30 PM the door of the resident's room 206 had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/21/14 at 2:42 PM the door of the resident's room 206 had wood that was chipped and splintered on the bottom half of the front of the door.

h. Observations of Room 208 during the initial tour of the facility on10/12/14 at 12:08 PM revealed the door of the resident's room had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/13/14 at 2:50 PM the door of the resident's room 208 had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/14/14 at 3:30 PM the door of the resident's room 208 had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/21/14 at 2:42 PM the door of the resident's room 208 had wood that was chipped and splintered on the bottom half of the front of the door.

i. Observations of Room 210 during the initial tour of the facility on 10/12/14 at 12:08 PM revealed the door of the resident's room had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/13/14 at 2:50 PM the door of the resident's room 210 had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/14/14 at 3:30 PM the door of

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 10/28/2014

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

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F 253	Continued From page 46	F 253		

the resident's room 210 had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/21/14 at 2:42 PM the door of the resident's room 210 had wood that was chipped and splintered on the bottom half of the front of the door.

j. Observations of Room 212 during the initial tour of the facility on 10/12/14 at 12:08 PM revealed the door of the resident's room had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/13/14 at 2:50 PM the door of the resident's room 212 had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/14/14 at 3:30 PM the door of the resident's room 212 had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/21/14 at 2:42 PM the door of the resident's room 212 had wood that was chipped and splintered on the bottom half of the front of the door.

k. Observations of Room 213 during the initial tour of the facility on 10/12/14 at 12:08 PM revealed the door of the resident's room had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/13/14 at 2:50 PM the door of the resident's room 213 had wood that was chipped and splintered on the bottom half of the front of the door.
Observation on 10/14/14 at 3:30 PM the door of the resident's room 213 had wood that was chipped and splintered on the bottom half of the front of the door.

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 10/28/2014

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 253	Continued From page 47	F 253		

Observation on 10/21/14 at 2:42 PM the door of the resident's room 213 had wood that was chipped and splintered on the bottom half of the front of the door.

During an interview on 10/21/14 at 2:42 PM with the Maintenance Director during an environmental tour he acknowledged the splintered wood and laminate on resident doors. He explained he had noticed the broken wood and laminate on the doors and they would have to be repaired with new laminate or have skins added to cover the splintered and jagged edges. He stated some of the doors would have to be replaced but he did not have funds in his departmental budget to fix them.

During an interview on 10/22/14 at 9:18 AM the Administrator explained she was aware of the broken wood and laminate on resident's doors and they needed to be fixed but the funds for the capital expenditures in the budget had not been approved for the new fiscal year.

4. a. During an observation on 10/13/14 at 08:45 AM in the bathroom of room 301 there was a bed pan on the floor next to the commode. There was no covering over the bedpan and there was no name visible on the bedpan.

Observations on 10/14/13 at 3:55 PM in the bathroom of room 301 revealed the bed pan was still located on the floor next to the commode. There was no covering over the bedpan and there was no name visible.

Observation on 10/15/14 at 11:29 AM in the bathroom of room 301 revealed the bed pan remained on the floor next to the commode.

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 10/28/2014

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 253	Continued From page 48	F 253		

There was no covering over the bedpan and there was no name visible.

During an interview and observation on 10/15/14 at 3:30 PM with Nurse Aide #6 stated it was the expectation for staff to write the resident's name on the bedpan with a marker and store the bedpan in a plastic bag on a hook in the bathroom. She further stated bedpans should not be stored on the floor in the bathroom.

During an interview on 12/15/14 at 3:40 PM with Nurse #4 she explained bed pans should have a resident's name written on them with black marker so the Nurse Aides would know which bed pan belonged to the resident. She stated bed pans should be stored in a plastic bag and hung on the hook in the bathroom. She confirmed the bedpan was located on the floor of the bathroom next to the toilet in room 301 and stated it should have been labeled with a resident's name and it should not have been left on the floor. She explained it should have been placed in a plastic bag and hung on a hook in the bathroom.

During an interview on 10/15/14 at 4:12 PM the Director of Nursing stated it was his expectation that bedpans would be labeled with a resident's name and stored in a plastic bag on a hook in the bathroom. He stated it was his expectation for nursing staff and housekeeping staff to check to make sure bedpans were labeled and stored properly. He further stated bedpans should not be left on the floor in bathrooms.

b. During an observation on 10/13/14 at 9:10 AM in the bathroom of room 213 there was a clear plastic bag with a bed pan inside of it hanging on a hook on the wall. The plastic bag had streaks

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 10/28/2014

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 253	Continued From page 49	F 253		

of brown stains down the side of the bag and there was no name on the bag or visible on the bedpan.

Observations on 10/14/14 at 9:16 AM in the bathroom of room 213 revealed there was a clear plastic bag with a bed pan inside of it hanging on a hook on the wall. The plastic bag still had brown stains on the outside of the bag and there was no name visible on the bedpan.

Observations on 10/15/14 at 9:00 AM in the bathroom of room 213 revealed there remained a clear plastic bag with a bed pan inside of it hanging on a hook on the wall. The plastic bag still had streaks of brown stains down the side of the bag and there was no name on the bag or visible on the bedpan.

During an interview and observation on 10/15/14 at 3:30 PM with Nurse Aide #6 who was assigned to work on the 3:00 PM to 11:00 PM shift on the 200 hall stated it was the expectation for staff to write the resident's name on the bedpan with a marker and store the bedpan in a plastic bag on a hook in the bathroom. She verified the bed pan located on the hook in the bathroom of room 213 was not labeled with a resident's name. She stated the brown stains that were down the side of the plastic bag should not be there. She explained she had no idea who the unlabeled bedpan belonged to because she did not use a bedpan for either of the residents in room 213. She stated she had no idea of who put it there or why it wasn't labeled but it should be thrown away.

During an interview on 12/15/14 at 3:40 PM with Nurse #4 she explained bed pans should have a

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 10/28/2014

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 253	Continued From page 50	F 253		

resident's name written on them with black marker so the Nurse Aides would know which bed pan belonged to the resident. She stated bed pans should be stored in a plastic bag and hung on the hook in the bathroom. She verified the bedpan located in a plastic bag on a hook in the bathroom of room 213 was not labeled with a resident's name and there was a brown substance on the side of the plastic bag. She stated both the bedpan and the plastic bag should be discarded.

During an interview on 10/15/14 at 4:12 PM the Director of Nursing stated it was his expectation that bedpans would be labeled with a resident's name and stored in a plastic bag on a hook in the bathroom. He stated it was his expectation for nursing staff and housekeeping staff to check to make sure bedpans were labeled and stored properly.

5. During an observation on 10/13/14 at 9:10 AM in the bathroom of room 213 there was a strong odor of stale urine and there were large reddish/brown stains on the floor around the base of the toilet. The lid of the water containment tank at the back of the toilet was turned partially to the side and only partially covered the tank.

During an observation on 10/14/14 at 9:16 AM in the bathroom of room 213 there remained strong odors of stale urine with large reddish/brown stains on the floor around the base of the toilet. The lid of the water containment tank at the back of the toilet was still partially turned to the side so that it only partially covered the tank.

During an observation on 10/15/14 at 9:00 AM in the bathroom of room 213 there were still strong

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 10/28/2014

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 253	Continued From page 51	F 253		

odors of stale urine with large reddish/brown stains on the floor around the base of the toilet. The lid of the water containment tank at the back of the toilet was still partially turned to the side so that it only partially covered the tank.

During an environmental tour on 10/21/14 at 2:42 PM the Maintenance Director verified the lid on the water containment tank on the back of the toilet in the bathroom of 213 did not fit the toilet. He explained the lid was partially turned to the side because when residents bumped into the toilet the lid became dislodged because it didn't fit properly. The Maintenance Director also confirmed the floor in the bathroom of room 213 was stained and he had been told that housekeeping was supposed to clean the floor and buff it but he had not seen that done. He explained once the floor was cleaned and buffed if the stains did not come out then the floor would have to be replaced. He stated he did not think buffing the floor would help and confirmed the bathroom smelled of stale urine. He stated sometimes the bathroom smelled worse than others and housekeeping staff had to stay on top of it every day to clean it and minimize odors.

During an observation and interview on 10/21/14 at 4:03 PM the Director of Housekeeping and Laundry stated he had only worked in the facility for 3 months. He further stated he had not been told anything about the floor of the bathroom in room 213. He verified the floor was stained around the base of the toilet and he could try to clean the stains but it was going to be difficult. He explained he did not think he could remove the stains and thought the flooring would have to be removed to fix it. He stated the bathroom smelled like urine and pointed to a large space

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 10/28/2014

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 253	Continued From page 52	F 253		

behind the toilet where the flooring had separated from the wall and exposed the concrete floor. He explained urine had probably gotten down under the flooring and under the base of the toilet and it couldn't be cleaned out.

During an interview on 10/22/14 at 9:18 AM with the Administrator she stated she thought the bathroom in room 213 was a bathroom that had been identified in the past that had urine odors. She verified there was no specific plan for addressing odors in the bathroom but only a generalized plan for cleaning bathroom floors.

6. On 10/12/14 at 3:53 PM a tour of the 300 hall commenced with initial observations. The subsequent observations each day revealed the following environmental concerns:

Resident #68 residing in a room shared by 2 residents' revealed debris and food substances in the room floor.

Observations were as follows:

1) 10/13/14 at 8:45 AM room floor dirty with debris and food substance
2) 10/13/14 at 3:58 PM room floor dirty with dried food substance and debris
3) 10/14/14 at 9:13 AM room floor remained dirty with debris and dried food substance

Resident #1 residing in a room alone revealed the room floor was dirty with debris, food substance, and dried liquid; which was noted to be sticky when walking in the room.

Observations were as follows:

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 10/28/2014

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 253	Continued From page 53	F 253		

1) 10/14/14 at 5:09 PM dried liquid spills, debris, and food substance on left side of Resident #1's bed, in front of the night stand, and all around the floor between the two beds in the room

2) 10/15/14 at 9:13 AM dried liquid spills, debris, and food substance; which included bread crumbs and dried eggs in the floor to the left side of Resident #1's bed and in front of the night stand and the breakfast tray setting on the over bed table

3) 10/15/14 at 2:48 PM dried liquid spills, debris, and dried food substance; the bread crumbs and dried eggs remained in the floor to the left side of Resident #1's bed, and her lunch tray was setting on the over bed table

4) 10/16/14 at 10:38 AM dried liquid spills, debris, and dried food substance remained in the floor in Resident #1's room

5) 10/16/14 at 5:13 PM Resident #1's room floor remained dirty with dried food substance, debris, and dried liquid spills

6) 10/17/14 at 8:23 AM room floor with bread crumbs, dried food substance, cup of milk spilled on the floor, and the floor remained dirty and sticky when walking in the room

On 10/17/14 at 9:33 AM Housekeeper #3 was interviewed. She stated the housekeepers were expected to clean each resident room every day. She indicated she was unaware Resident #1's room was dirty with debris and dried food substance. She further indicated she cleaned the room on 10/11/14 but was unaware if it had been cleaned since that time.

On 10/17/14 at 9:57 AM Housekeeper #4 was interviewed. She stated she had cleaned the odd numbered rooms on the 300 hall but had not

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 10/28/2014

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 253	Continued From page 54	F 253		

cleaned the even numbered rooms which would have included Resident #1's room. She further stated the housekeeping staff was expected to clean the resident rooms every day but there were days when it was not done.

On 10/17/14 at 10:34 AM the Director of Housekeeping was interviewed. He stated he expected the resident rooms to be cleaned every day. He indicated he was aware the resident rooms were not cleaned every day and he had tried to clean the resident rooms but ran out of time.

On 10/21/14 at 3:35 PM the Administrator was interviewed. She stated her expectation was for the resident's rooms and bathrooms to be cleaned every day.

7. Resident #68 was admitted to the facility on 09/12/14. Her diagnoses included muscle weakness, chronic airway obstruction, osteoarthritis, anxiety, history of falls, and chronic pain. Resident #68's Annual Minimum Data Set (MDS) dated 09/23/14 revealed she was cognitively intact, interviewable, and was capable of making her needs known. The MDS further assessed the resident as needing limited assistance of one person for her activities of daily living (ADLs).

During an observation on 10/12/14 at 3:53 PM, the bathroom shared by 3 residents between rooms 310 and 312 was observed to be without toilet paper and no hand drying paper towels in the dispenser.

During an observation on 10/13/14 at 8:45 AM, the bathroom between rooms 310 and 312 had

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 10/28/2014

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 253	Continued From page 55	F 253		

no toilet paper or hand drying paper towels in the dispenser.

During an interview on 10/13/14 at 8:45 AM with Resident #68, she stated the bathroom was shared by her and 2 other residents. She further stated there were a lot of days that no toilet paper or hand drying paper towels were placed in the bathroom. She indicated the hand drying paper towels in the dispenser located at the sink in her room was what she used when she went to the toilet.

During an observation on 10/13/14 at 9:29 AM, a housekeeper was pushing her cleaning cart down the 300 hallway; observed 1 stack of hand drying paper towels on top of the cart and no toilet paper visible on the top of the cleaning cart, she stopped at room 312, briefly talked with the 2 residents, and continued to make her way to the 400 hall.

During an observation on 10/13/14 at 11:29 AM, a housekeeper was observed cleaning the odd numbered rooms on the 300 hall with no toilet paper or hand drying paper towels visible on the top of the housekeepers cleaning cart.

During an observation on 10/13/14 at 3:58 PM, the bathroom; between resident rooms 310 and 312, remained with no toilet paper or hand drying paper towels in the dispenser and a hand drying paper towel was observed in the toilet.

During a follow-up interview on 10/13/14 at 5:13 PM with Resident #68, she stated she would take 2 hand drying paper towels from the dispenser at her sink into the bathroom when she had to use the toilet. She indicated the housekeeping staff

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 10/28/2014

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 253	Continued From page 56	F 253		

had not put toilet paper or hand drying paper towels in the bathroom since 10/10/14. During the interview, the activities assistant was observed to take toilet paper into the bathroom.

During an interview on 10/13/14 at 5:26 PM with the activities assistant, he stated he was unaware the bathroom had not been stocked with toilet paper or hand drying paper towels. He indicated the family member had requested toilet paper and that was what he had provided to them. He further indicated he had not been asked for bathroom supplies before this time.

During an interview on 10/15/14 at 9:45 AM with housekeeping staff #3, she stated it was the responsibility of the housekeeping staff to stock the resident bathrooms with toilet paper and hand drying paper towels each day. She indicated she was unaware the bathroom was without supplies and was unable to recall the last time the bathroom was stocked with toilet paper or hand drying paper towels. She further stated the housekeeping staff was expected to check and/or stock the resident bathrooms each day but there were days when it was not done.

During an interview on 10/15/14 at 3:02 PM with the Director of Housekeeping, he stated he expected the bathrooms to be checked and stocked with toilet paper and hand drying paper towels each day. He further stated he was unaware the bathrooms had not been stocked every day.

During an interview on 10/15/14 at 3:53 PM with the Administrator, she stated her expectation was for the residents bathrooms to be stocked with toilet paper and hand drying paper towels at all

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 10/28/2014

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 253	Continued From page 57 times.	F 253		
F 254 SS=D	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide bed linens in clean condition for 1 of 1 resident reviewed for cleanliness of bed linens. (Resident #1). The findings included: Review of the medical record revealed Resident #1 was re-admitted to the facility on 10/12/13 and the most recent Quarterly Minimum Data Set (MDS) dated 08/26/14 revealed Resident #1 was severely impaired for cognitive skills for daily decision making. Review of the facility record shower list revealed Resident #1 was scheduled to receive showers on Monday and Thursdays. During an observation on 10/12/14 at 3:53 PM Resident #1's bed was un-made which revealed bread crumbs in the bed, a 2 inch long by ½ inch wide purple colored stain on the top middle portion of the fitted sheet, a dark red colored stain on the pillow case. During an observation on 10/13/14 at 8:45 AM Resident #1's bed linen sheets remained with the same purple colored stain on the top middle	F 254	1. No residents were injured related to this citation. Resident #1 bed linens were changed on 10/21/2014 by certified nurse assistant. 2. All residents have the potential to be affected by this citation. Observations of linens in residents rooms was completed by the Interdisciplinary team (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records), 11/18/2014-11/21/2014. 3. Licensed Nurses and Certified Nurse Assistance were in serviced by the Director of Clinical Services on changing linens on shower days and more often if soiled 11/10/2014-12/04/2014.The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records), will perform Quality Improvement monitoring of linens in 10 residents rooms 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks and 1 time a week for 4 weeks and/or	12/5/14

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 10/28/2014

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 254	Continued From page 58 portion of the fitted sheet, the dark red colored stain on the pillow case, and with observation of dried egg and bread crumbs in the bed. During an observation on 10/13/14 at 3:58 PM Resident #1's bed linen sheets remained with the same purple colored stain on the top middle portion of the fitted sheet, the dark red colored stain on the pillow case, and with observation of potato chip crumbs in the bed. During an observation on 10/14/15 at 5:09 PM Resident #1's bed linen sheets remained with the same purple colored stain on the top middle portion of the fitted sheet and the dark red colored stain on the pillow case. During an observation on 10/15/14 at 9:13 AM Resident #1's bed linen sheets remained with the same purple colored stain on the top middle portion of the fitted sheet, the dark red colored stain on the pillow case, and bread crumbs in the bed. During an observation on 10/15/14 at 2:48 PM Resident #1's bed linen sheets remained with the same purple colored stain on the top middle portion of the fitted sheet and the dark red colored stain on the pillow case, and with observation of potato chip crumbs in the bed. During an interview on 10/15/14 at 2:53 PM with Nursing Assistant (NA) #12 responsible for the showers of residents 5 days a week stated Resident #1 received showers on Monday and Thursdays. NA #12 stated she was unsure but thought Resident #1 had a shower on Thursday 10/09/14. NA #12 further stated the NAs assigned to the residents on the halls were responsible for	F 254	substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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 254	Continued From page 59	F 254		

changing the bed linens on the resident's shower days and as needed when linens were dirty or soiled.

During an observation on 10/16/14 at 10:26 AM PM Resident #1's bed linen sheets remained with the same purple colored stain on the top middle portion of the fitted sheet and the dark red colored stain on the pillow case.

During an interview on 10/16/14 at 2:23 PM with NA #8 stated he was unaware of Resident #1's last shower or when the bed linens were changed. NA #8 explained that showers included, hair washing, nail care, clean clothes, and clean bed linens. He stated he had not changed Resident #1's bed linens or assisted her with a shower on Monday or Thursday. He further stated Resident #1 has refused showers, would become agitated easily, and so the NAs tend to leave her alone. He stated he was unable to recall if she had refused a shower on Monday or Thursday.

During an observation on 10/16/14 at 5:04 PM Resident #1's bed linen sheets remained with the same purple colored stain on the top middle portion of the fitted sheet and the dark red colored stain on the pillow case.

During an observation on 10/17/14 at 8:32 AM Resident #1's bed linen sheets remained with the same purple colored stain on the top middle portion of the fitted sheet, the dark red colored stain on the pillow case, and with observation of potato chip crumbs in the bed.

During an interview on 10/17/14 at 9:05 AM Nurse #7 confirmed Resident #1's bed linens were soiled with a purple colored stain on the top

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 254	Continued From page 60 middle portion of the fitted sheet, the dark red colored stain on the pillow case, the bread crumbs in the resident's bed, and it should have been changed on the resident's shower day and any time they were soiled. The nurse further stated it was her expectation that sheets were changed on shower days Mondays and Thursdays for Resident #1 or anytime they were soiled. During an interview on 10/21/14 at 3:35 PM the Director of Nursing (DON) stated it was his expectation the bed linens should be changed twice a week on the resident shower days Mondays and Thursdays and more often when the linens were soiled. During an interview on 10/21/14 at 3:35 PM the Administrator stated it was her expectation that soiled linens should be changed on resident's shower days and more frequently when they were soiled.	F 254		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;	F 272		12/5/14

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 10/28/2014

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F 272	Continued From page 61 Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to comprehensively assess 10 of 28 sampled residents identifying how their condition affected each resident's function and quality of life. (Residents #1, #11, #34, #58, #60, #61, #69, #81, #91, and #100). The findings included: 1. Resident #100 was admitted to the facility on 04/17/14. Her diagnoses included Parkinson's disease, history of traumatic brain injury,	F 272	1. Resident #1 was assessed by the physician on 11/18/2014 with no new orders. Resident #11 no longer resides at the facility. Resident #34 was assessed by the physician on 11/18/2014 with no new orders. Resident #58 no longer resides at the facility. Resident #60 was assessed by the physician on 11/18/2014 with new orders	

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 10/28/2014

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F 272	Continued From page 62 dementia, gastroesophageal reflux, hypothyroidism and hyperlipidemia. The admission Minimum Data Set (MDS) dated 04/24/14 coded her with usually being understood and usually understands, having some inattention and disorganized thinking, having moderately impaired cognition (scoring a 10 out of 15 on the brief interview for mental status), requiring total assistance with bathing, extensive assistance with bed mobility, transfers, toileting and limited assistance with ambulation in room, hygiene and dressing. She was coded as needing assistance of staff to balance, being frequently incontinent of urine and receiving antipsychotic medications in the previous 7 days. Review of the Care Area Assessments (CAA) dated 04/30/14 revealed the following areas were not analyzed with the MDS information to determine the resident's strengths, weaknesses and how her condition affected those areas: a. Cognition CAA: under nature of condition was her age and diagnoses; under complications and risk factors the MDS information was listed; and under factors to consider were care plan interventions. There was no analysis of how her cognitive impairment affected her day to day routine or decision making or quality of life. b. ADL CAA: under nature of condition was her age and diagnoses; under complications and risk factors the MDS information was listed; and under factors to consider were care plan interventions. There was no analysis related to if any of her ADLs could improve or how they affected her function and quality of life. c. Urinary Incontinence CAA: under nature of condition was her age and diagnoses; under complications and risk factors was the potential	F 272	noted. Resident # 61 was assessed by the physician on 11/18/2014 with new orders noted. Resident #64 was assessed by the physician on 11/18/2014 with no new orders noted. Resident # 81 was assessed by the physician on 11/18/2014 with no new orders noted. Resident # 91 was assessed by the physician on 11/18/2014 with no new orders noted. Resident # 100 was assessed by the physician on 11/18/2014 with orders noted. 2. All residents have the potential to be affected by this citation. An audit of current residents last two assessments, Minimum Data Set was completed 11/10/2014-12/04/2014 by the Regional Case Mix Coordinator.. 3. The Regional Case Mix Coordinator in serviced the Minimum Data Assessment Nurse, Director of Social Services, Activities Director, Dietary Director and the Director of Nursing and/or Nursing Supervisor on Documentation of the Minimum Data Assessment and the Care Area Assessments (CAA) to include what goes into the CAAs on 11/19/2014-11/20/2014. The Director of Clinical Services will perform Quality Improvement monitoring of the Minimum Data Set/Care Area Assessments 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a	

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

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F 272	Continued From page 63 for urinary tract infections and the use of briefs; and under factors to consider were care plan interventions. There was no analysis to determine how her incontinence affected her day to day life or if her incontinence could improve. d. Nutrition CAA: under nature of condition was her age and diagnoses; under complications and risk factors was her risk for weight loss due to varied intake; and under factors to consider were care plan interventions. There was no analysis of the information to determine the reason her intake varied. e. Psychotropic drug use CAA: under nature of condition was her age and diagnoses; under complications and risk factors was the potential for adverse side effects related to the use of psychotropic medications; and under the factors to consider was the care plan interventions. There was no analysis to identify the reason for the psychotropic medications and the affects the medication had on her quality of life. Interview with the MDS Coordinator on 10/16/14 at 1:47 PM revealed she completed all the MDSs and CAAs in the building. As of a few weeks ago, other department heads started to complete different sections of the MDS. When completing a CAA, the MDS Coordinator stated she looked at all the information gathered, talked to the resident and staff and read the documentation in the medical record. She stated the nature of the condition was the age and admitting diagnoses. The complication of the condition was what she was going to do for the resident. She further stated she had been trained that the CAA information had to match what the care plan interventions included. She then stated her consultant has read the CAA but never mentioned that information was missing. MDS Coordinator	F 272	week for 8 weeks and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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F 272	Continued From page 64	F 272		

stated she was trained under the MDS 2.0 version but was never instructed as to what information needed to be included in the CAA. Per the MDS Coordinator, all the CAAs were written the same way with no analysis of the information just the repeat of a residents age, diagnoses, MDS information and care plan interventions.

2. Resident #61 was admitted to the facility on 09/28/12 and most recently readmitted on 09/14/14. His diagnoses included anemia, gastric intestinal bleeding, quadriplegia, hypertension, chronic pain, anxiety, depression, urinary tract infections.

His annual Minimum Data Set (MDS) dated 09/21/14 coded him as having no cognitive impairments, having verbal behaviors 1 - 3 days in the previous 7 days, requiring total assistance for all activities of daily living skills, being nonambulatory and receiving psychiatric therapy.

Review of the Care Area Assessments (CAA) dated 09/30/14 revealed the following areas were not analyzed with the MDS information to determine the resident's strengths, weaknesses and how his condition affected those areas as follows:
a. Behavior CAA (which also incorporated the area of cognition, psychosocial well-being and behaviors) stated under nature of condition was his age and diagnoses; under complications and risk factors was "individual coping ineffective R/T (related to) behaviors"; and under factors to consider were the care plan interventions. There was no description of his behaviors, cognition or psychosocial well being or how they interacted upon one another or any analysis of how his

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 272	Continued From page 65 every day quality of life was impacted or affected. b. Mood CAA: under nature of condition was his age and diagnoses,; under complications and risk factors was "individual coping ineffective R/T (related to) behaviors"; and under factors to consider were the care plan interventions. There was no description of his mood, what affected his mood, or any analysis of how his quality of life was affected or impacted. c. Psychotropic Drug Use CAA: under nature of condition was his age and diagnoses; under complications and risk factors was the potential for adverse side effects related to the use of psychotropic medications; and under factors to consider were the care plan interventions. There was no analysis to identify the reason for the psychotropic medications and the affects the medication had on his quality of life. Interview with the MDS Coordinator on 10/16/14 at 1:47 PM revealed she completed all the MDSs and CAAs in the building. As of a few weeks ago, other department heads started to complete different sections of the MDS. When completing a CAA, the MDS Coordinator stated she looked at all the information gathered, talked to the resident and staff and read the documentation in the medical record. She stated the nature of the condition was the age and admitting diagnoses. The complication of the condition was what she was going to do for the resident. She further stated she had been trained that the CAA information had to match what the care plan interventions included. She then stated her consultant has read the CAA but never mentioned that information was missing. MDS Coordinator stated she was trained under the MDS 2.0 version but was never instructed as to what information needed to be included in the CAA.	F 272		

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 272	Continued From page 66	F 272		

Per the MDS Coordinator, all the CAAs were written the same way with no analysis of the information just the repeat of a residents age, diagnoses, MDS information and care plan interventions.

3. Resident #58 was admitted to the facility on 09/03/14 with diagnoses including chronic respiratory failure, end stage chronic obstructive pulmonary disease, chronic pain, esophageal reflux, osteoporosis, anxiety and vitamin D deficiency.

The admission Minimum Data Set (MDS) dated 09/12/14 coded her with intact cognitive impairment, limited assistance needed for most activities of daily living skills (ADLs), utilizing oxygen, receiving a mechanically altered diet and weighing 96 pounds being 5 feet 6 inches tall.

Review of the Care Area Assessments (CAA) dated 09/16/14 for the areas of ADLs, nutritional status, pressure ulcers and pain did not analyze the MDS information to determine the resident's strengths, weaknesses and how her condition affected those areas as follows:
a. ADLS CAA: under nature of condition was her age and diagnoses; under complications and risk factors the MDS information was listed; and under factors to consider were care plan interventions. There was no analysis of her strengths and weaknesses and/or how her quality of life was affected by her condition.
b. Nutritional CAA: under nature of condition was her age and diagnoses; under complications and risk factors was the potential for weight loss related to receiving a mechanically altered diet and having varied intake but not that she was underweight; and under factors to consider were

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 10/28/2014

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

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F 272	Continued From page 67	F 272		

care plan interventions. There was no analysis of her strengths and weaknesses or how her poor intake and being underweight affected her quality of life or her nutritional status.
c. Pressure ulcer CAA: under nature of condition was her age and diagnoses; under complications and risk factors was the potential for skin integrity impairment related to decreased mobility; and under factors to consider were care plan interventions. There was no mention that she had excoriation on her skin upon admission or any analysis of her other strengths and weaknesses that affected her skin's ability to heal.
d. Pain CAA: under nature of condition was her age and diagnoses; under complicating and risk factors was her potential for alteration in comfort related to complaints of pain due to her diagnoses of chronic pain; and under factors to consider were the care plan interventions. There was no analysis of the type of pain she was in or why she was in pain or how it affected her ability to breathe.

Interview with the MDS Coordinator on 10/16/14 at 1:47 PM revealed she completed all the MDSs and CAAs in the building. As of a few weeks ago, other department heads started to complete different sections of the MDS. When completing a CAA, the MDS Coordinator stated she looked at all the information gathered, talked to the resident and staff and read the documentation in the medical record. She stated the nature of the condition was the age and admitting diagnoses. The complication of the condition was what she was going to do for the resident. She further stated she had been trained that the CAA information had to match what the care plan interventions included. She then stated 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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 272	Continued From page 68	F 272		

consultant has read the CAA but never mentioned that information was missing. MDS Coordinator stated she was trained under the MDS 2.0 version but was never instructed as to what information needed to be included in the CAA. Per the MDS Coordinator, all the CAAs were written the same way with no analysis of the information just the repeat of a residents age, diagnoses, MDS information and care plan interventions.

4. Resident #81 was admitted on 05/26/13 with diagnoses including Alzheimer's disease, dementia, debility, and a history of falls. A quarterly Minimum Data Set (MDS) dated 08/15/14 revealed Resident #81 had severely impaired cognition, walking did not occur, balance during transitions was not steady, and restraints were not used.

Review of Resident #81's medical record from August of 2014 through October of 2014 revealed no assessment for the use of a restraint or thigh belts.

Review of a SBAR (Situation, Background, Assessment, and Request) form completed by Nurse #9 on 08/12/14 revealed Resident #81 had slipped from her specialized wheel chair on to the floor. Nurse #9 documented she recommended a Physical Therapy (PT) evaluation for a belt to keep Resident #81 positioned at the back of her chair.

Review of a nurse's note dated 08/13/14 at 1:15 PM revealed Nurse #9 noted Resident #81 had a soft belt in place to prevent her from sliding out of her chair. Nurse #11 documented on 08/13/14 and 08/14/14 during the 3:00 PM to 11:00 PM

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 10/28/2014

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 272	Continued From page 69	F 272		

shift that Resident #81 had a soft belt in place to prevent her from sliding out of her wheel chair. Continued review of nurse's notes from 08/13/14 through 10/13/14 revealed no further documentation regarding either the soft belt or the thigh belts.

Observations on 10/12/14 at 12:06 PM revealed Resident #81 was sitting in a specialized wheel chair in the hallway. Padded straps approximately 3 inches wide were observed coming from the seat of the chair, over both thighs, and attached at the back of the chair behind her hips (thigh belts). On 10/12/14 at 3:01 PM Resident #81 was observed propelling herself in the hall. Thigh belts were noted bilaterally. A subsequent observation on 10/13/14 at 10:54 AM revealed Resident #81 in her specialized wheel chair with thigh belts in place bilaterally. When Resident #81 was observed in the day room on 10/14/14 at 8:45 AM the thigh belts had been removed.

An interview was conducted with Nurse #11 on 10/15/14 at 5:19 PM. During the interview Nurse #11 confirmed she documented Resident #81 had a soft belt in place on 08/13/14 and 08/14/14 and assumed Nurse #9 had received a physician's order for the use of the soft belt after the fall on 08/12/14. Nurse #11 could not recall when the soft belt/thigh belts were discontinued.

During an interview on 10/16/14 at 1:30 PM Nurse #9 stated she spoke with the Director of Nursing (DON) on 08/12/14 about possibly using leg positioning straps to prevent Resident #81 from scooting forward and out of her specialized wheel chair and thought therapy was consulted. Nurse #9 did not recall how long the leg

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 10/28/2014

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 272	Continued From page 70	F 272		

positioning straps were in use for Resident #81 or when they were discontinued.

An interview with the DON on 10/16/14 at 3:34 PM revealed the facility reviewed restraints regularly and all residents with restraints should have an assessment for the use of the restraint. The DON did not recall having a conversation with Nurse #9 after Resident #81 fell on 08/12/14. The DON stated Resident #81 had not been discussed for the use of any kind of restraint since he began working at the facility in late June of 2014. Resident #81 was discussed in the fall meeting on 08/13/14 and was referred to therapy for an evaluation of positioning in her specialized wheel chair. The DON explained he noticed the thigh belts on Resident #81's chair at lunch on 10/13/14 and told a nurse aide to remove them because the resident did not need them. The DON could not explain why the thigh belts were observed in use on 10/12/14 or 10/13/14 or how they got on Resident #81's specialized wheel chair.

An interview was conducted with Nurse Aide (NA) #9 on 10/21/14 at 10:59 AM. NA #9 confirmed she cared for Resident #9 on 10/13/14 and recalled Resident #81 had the thigh belts in use when she was up in her specialized wheel chair. NA #9 stated she did not work on Resident #81's hall often and did not know when the thigh straps were initiated or discontinued.

An interview with NA #3 on 10/21/14 at 11:17 AM revealed she cared for Resident #81 on 10/13/14 and recalled the thigh straps were in use. NA #3 stated she worked on Resident #81's hall occasionally and was not sure when the thigh belts were initiated or discontinued.

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 272	Continued From page 71	F 272		

During an interview on 10/21/14 at 12:14 PM Nurse #10 confirmed she cared for Resident #81 on 10/12/14 during the 7:00 AM to 3:00 PM shift and did not recall if the thigh belts were in use or not. Nurse #10 stated Resident #81 had thigh belts in place at one time but did know when or if they had discontinued.

An interview with the Therapy Director on 10/22/14 at 10:45 AM revealed he assessed Resident #81 on 08/15/14 and did not make any changes as Resident #81 had good positioning in her specialized wheel chair.

5. Resident #60 was readmitted to the facility 08/15/14 with diagnoses which included debility, history of urinary tract infections, and urinary retention. An admission Minimum Data Set (MDS) dated 08/22/14 indicated the resident's cognition was intact. The MDS specified Resident #60 required extensive staff assistance for bed mobility, transfers, and dressing and was dependent on staff for toileting. The MDS further noted the resident had an indwelling urinary catheter.

A Care Area Assessment (CAA) dated 08/22/14 related to an indwelling urinary catheter specified Resident #60 was at risk for urinary tract infections. Interventions guiding the staff to care for the indwelling catheter were provided in the CAA. Further CAA documentation did not contain a diagnosis to support urinary catheter use nor explain why the resident had an indwelling urinary catheter. The CAA did not specify if the facility had a goal to remove the indwelling urinary catheter.

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 10/28/2014

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 272	Continued From page 72 Interview with the MDS coordinator on 10/16/14 at 1:47 PM revealed she completed all the MDS and CAAs in the building. When completing a CAA, the MDS coordinator stated she looked at all the information gathered, talked to the resident and staff and read the documentation in the medical record. She stated the part of the CAA identified as nature of the condition was the age and admitting diagnoses. The complication of the condition was what she was going to do for the resident. She further stated she had been trained that the CAA information had to match what the care plan interventions included. Per the MDS Coordinator, all the CAAs were written the same way with no analysis of the information just the repeat of a resident's age, diagnoses, MDS information and care plan interventions. 6. Resident #1's original admission date to the facility was 07/15/94 with a re-admission date of 10/12/13. Her diagnoses included schizophrenia, depressive disorder, high blood pressure, hyperlipidemia, and Diabetes Mellitus. The Quarterly Minimum Data Set (MDS) dated 08/26/14 coded Resident #1 with usually being understood and usually understands, unclear speech, difficulty communicating, and severe impaired cognition, independent for bed mobility, transfer, ambulation, dressing, eating, toileting, and personal hygiene, activity of bathing did not occur and no assessment for assistance identified. Resident #1 was coded as unsteady with balance and always continent of urine and bowel, and receiving antipsychotics and antidepressants in the previous 7 days.	F 272		

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 10/28/2014

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 272	Continued From page 73 Review of the Care Area Assessment dated 09/09/14 revealed under the areas of cognition, activities of daily living (ADLs), nutrition, and psychotropic medications did not analyze the MDS information to determine Resident #1's strengths, weaknesses, and how her condition affected those areas as follows: a) Cognition CAA: under nature of condition was Resident #1's age and diagnoses; under complications and risk factors the MDS information was listed; and under factors to consider were the care plan interventions. There was no analysis of how her cognitive impairment affected her day to day routine or decision making. b) ADL CAA: under nature of condition was her age and diagnoses; under complications and risk factors the MDS information was listed; and under factors to consider were care plan interventions. There was no analysis related to if any ADLs could improve or how the ADLs affected Resident #1's day to day routine. c) Nutrition CAA: under nature of condition was her age and diagnoses; under complications and risk factors was her risk for weight loss due to varied intake; and under factors to consider were care plan interventions. There was no analysis of the information to determine the reason Resident #1's intake varied. d) Psychotropic Drug Use CAA: under nature of condition was her age and diagnoses; under complications and risk factors was the potential for adverse side effects related to the use of psychotropic medications; and under factors to consider were the care plan interventions. There was no analysis to identify the reason for the psychotropic medications and the affects the medications had on her quality of life.	F 272		

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 10/28/2014

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 272	Continued From page 74	F 272		

Interview with the MDS Coordinator on 10/16/14 at 1:47 PM revealed she completed all the MDSs and CAAs in the building. As of a few weeks ago, other department heads started to complete different sections of the MDS. She stated when completing a CAA, she looked at all the information gathered, talked to the resident and staff, and would read the documentation in the medical record. She stated the nature of the condition was the age and admitting diagnoses. The complication of the condition was what she was going to do for the resident. She further stated she had been trained that the CAA information had to match what the care plan interventions included. She indicated her consultant had read the CAA but had never mentioned that the information was missing. Per the MDS Coordinator, all the CAAs were written the same way with no analysis of the information just the repeat of a residents age, diagnoses, MDS information, and care plan interventions.

7. Resident #11 was admitted to the facility on 07/25/14 her diagnoses included dementia, cognitive/attention deficit, muscle weakness, lack of coordination, dehydration, and urinary tract infection.

The Admission Minimum Data Set (MDS) dated 08/01/14 coded Resident #11 with usually being understood and sometimes understanding, difficulty communicating, and severe impaired cognition, requiring total dependence on staff with toileting, extensive assistance with bed mobility, transfers, dressing, eating, personal hygiene, and bathing. Resident #11 was coded as unsteady with balance and needing assistance of staff, always incontinent of bowel, as having a urinary

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 10/28/2014

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 272	Continued From page 75	F 272		

catheter, and receiving antidepressants in the previous 7 days.

Review of the Care Area Assessment dated 08/06/14 revealed under the areas of cognition, activities of daily living (ADLs), urinary incontinence, falls, pressure ulcers, and psychotropic medications did not analyze the MDS information to determine Resident #11's strengths, weaknesses, and how her condition affected those areas as follows:

a) Cognition CAA: under nature of condition was Resident #11's age and diagnoses; under complications and risk factors the MDS information was listed; and under factors to consider were the care plan interventions. There was no analysis of how her cognitive impairment affected her day to day routine or decision making.
b) ADL CAA: there was no information or analysis of findings related to Resident #11's ADLs.
c) Urinary Incontinence and Indwelling Catheter CAA: under nature of condition was her age and diagnoses; under complications and risk factors was the potential for urinary tract infections related to indwelling urinary catheter use; and under factors to consider were care plan interventions. There was no analysis to determine how Resident #11's incontinence affected her day to day life or if her incontinence could improve or the use of an indwelling catheter could be discontinued.
d) Pressure Ulcer CAA: under nature of condition was her age and diagnoses; under complications and risk factors the MDS information was listed; and under factors to consider were the care plan interventions. There was no analysis of the information to determine the reason for pressure

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 10/28/2014

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 272	Continued From page 76	F 272		

ulcer development and/or prevention.
e) Psychotropic Drug Use CAA: under nature of condition was her age and diagnoses; under complications and risk factors was the potential for adverse side effects related to the use of psychotropic medications; and under factors to consider were the care plan interventions. There was no analysis to identify the reason for the psychotropic medications and the affects the medications had on her quality of life.

Interview with the MDS Coordinator on 10/16/14 at 1:47 PM revealed she completed all the MDSs and CAAs in the building. As of a few weeks ago, other department heads started to complete different sections of the MDS. She stated when completing a CAA, she looked at all the information gathered, talked to the resident and staff, and would read the documentation in the medical record. She stated the nature of the condition was the age and admitting diagnoses. The complication of the condition was what she was going to do for the resident. She further stated she had been trained that the CAA information had to match what the care plan interventions included. She indicated her consultant had read the CAA but had never mentioned that the information was missing. Per the MDS Coordinator, all the CAAs were written the same way with no analysis of the information just the repeat of a residents age, diagnoses, MDS information, and care plan interventions.

8. Resident #34's original admission date to the facility was 07/16/10 with a re-admission date of 10/29/13. His diagnoses included schizophrenia, dementia, behavioral problems, dermatitis, and skin problems.

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 10/28/2014

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 272	Continued From page 77	F 272		

The most recent Minimum Data Set (MDS) dated 08/01/14 coded Resident #34 with usually being understood and usually understands, difficulty communicating, and severe impaired cognition, requiring extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. He was coded as unsteady and needing assistance of staff to balance, being frequently incontinent of urine, always incontinent of bowel, and receiving antipsychotic, antianxiety, and antidepressants in the previous 7 days.

Review of the Care Area Assessments dated 08/13/14 revealed under the areas of cognition, urinary incontinence, falls, activities of daily living (ADLs), and psychotropic medications did not analyze the MDS information to determine Resident #34's strengths, weaknesses, and how his condition affected those areas as follows:

a) Cognition CAA: under nature of condition was Resident #34's age and diagnoses; under complications and risk factors the MDS information was listed; and under factors to consider were the care plan interventions. There was no analysis of how his cognitive impairment affected his day to day routine or decision making.
b) Urinary Incontinence CAA: under nature of condition was his age and diagnoses; under complications and risk factors was the potential for urinary tract infections related to incontinence and the use of briefs; and under factors to consider were the care plan interventions. There was no analysis to determine how his incontinence affected his day to day life or if his incontinence could improve.
c) Falls CAA: under nature of condition was Resident #34's age and diagnoses; under

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 10/28/2014

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 272	Continued From page 78	F 272		

complications and risk factors the MDS information was listed; and under factors to consider were the care plan interventions. There was no analysis of how the fall accidents affected his day to day routine, comfort, and/or fall prevention.
d) Psychotropic Drug Use CAA: under nature of condition was his age and diagnoses; under complications and risk factors was the potential for adverse side effects related to the use of psychotropic medications; and under factors to consider were the care plan interventions. There was no analysis to identify the reason for the psychotropic medications and the affects the medication had on his quality of life.

Interview with the MDS Coordinator on 10/16/14 at 1:47 PM revealed she completed all the MDSs and CAAs in the building. As of a few weeks ago, other department heads started to complete different sections of the MDS. She stated when completing a CAA, she looked at all the information gathered, talked to the resident and staff, and would read the documentation in the medical record. She stated the nature of the condition was the age and admitting diagnoses. The complication of the condition was what she was going to do for the resident. She further stated she had been trained that the CAA information had to match what the care plan interventions included. She indicated her consultant had read the CAA but had never mentioned that the information was missing. Per the MDS Coordinator, all the CAAs were written the same way with no analysis of the information just the repeat of a residents age, diagnoses, MDS information, and care plan interventions.

9. Resident #91 was admitted to the facility on

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 10/28/2014

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 272	Continued From page 79	F 272		

07/07/14 with diagnoses of coronary artery disease, hypertension, thyroid disorder and quadriplegia. The admission Minimum Data Set (MDS) dated 07/14/14 indicated Resident #91 was cognitively intact. The MDS further indicated Resident #91 requires total assistance with bathing, bed mobility, transfers, hygiene and dressing.

Review of the Care Area Assessment (CAA) dated 07/14/14 revealed the areas of activities of daily living (ADL), urinary incontinence/indwelling catheter, falls, nutritional status and pressure ulcers were not analyzed by using the MDS information to determine Resident #91's strengths, weaknesses and how his condition affected those areas as follows:

a. ADL CAA: under nature of condition was his age and diagnoses; under complications and risk factors to consider were care plan interventions. There was no analysis related to if any of his ADL could improve or how they affected her day to day routine.

b. Urinary incontinence/Indwelling catheter CAA: under nature of condition was his age and diagnoses; under complications and risk factors was the indwelling catheter due to a neurogenic bladder; under factors to consider were care plan interventions. There was no analysis to determine how his catheter affected his daily routine.

c. Falls CAA: under nature of condition was his age and diagnoses; under complications and risk factors was the potential for falls related to quadriplegia; under factors to consider were care plan interventions. There was no analysis as to determine cause of falls and how they could be prevented.

d. Nutrition CAA: under nature of condition was his age and diagnoses; under complications and risk factors was his risk for weight loss due to

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 10/28/2014

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 272	Continued From page 80	F 272		

varied intake; under factors to consider were care plan interventions. There was no analysis of the information to determine the reason his intake varied.
e. Pressure Ulcer CAA: under nature of condition was his age and diagnoses; under complications and risk factors were care plan interventions. There was no analysis of information to determine the reason for the pressures ulcers or how they affected his day to day routine.
Interview with the MDS coordinator on 10/16/14 at 1:47 PM revealed she completed all the MDS and CAAs in the building. As of a few weeks ago, other department heads started to complete different sections of the MDS. When completing a CAA, the MDS coordinator stated she looked at all the information gathered, talked to the resident and staff and read the documentation in the medical record. She stated the nature of the condition was the age and admitting diagnoses. The complication of the condition was what she was going to do for the resident. She further stated she had been trained that the CAA information had to match what the care plan interventions included. She then stated her consultant had read the CAA but never mentioned that information was missing. Per the MDS Coordinator, all the CAAs were written the same way with no analysis of the information just the repeat of a residents age, diagnoses, MDS information and care plan interventions.
10. Resident #69 was admitted to the facility on 09/10/14 with diagnoses of neuropathy, diabetes and lack of coordination. The admission Minimum Data Set dated 09/21/14 revealed Resident #69 was cognitively intact. The MDS further revealed she required extensive with bed mobility, transfers, dressing, toileting, hygiene and bathing.

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 10/28/2014

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 272	Continued From page 81 She was coded as needing assistance of staff to balance and being frequently incontinent of urine and receiving antianxiety and antidepressants in the previous 7 days. Review of the Care Area Assessments (CAA) dated 09/10/14 revealed under the areas of vision, activities of daily living (ADL), urinary incontinence, mood state, falls, and psychotropic drug use did not analyze the MDS information to determine the resident's strengths, weaknesses and how her condition affected those areas as follows: a. Vision CAA: under nature of condition was her age and diagnoses; under complications and risk factors the MDS information was listed; under factors to consider were care plan interventions. There was no analysis of how her vision affected her day to day life and if it could be improved. b. ADL CAA: under nature of condition was her age and diagnoses; under complications and risk factors was the MDS information; under factors to consider were the care plan interventions. There was no analysis related to if any of her ADL could improve or how they affected her day to day routine. c. Urinary incontinence CAA: under nature of condition was her age and diagnoses, under complications and risk factors was her MDS information; under factors to consider were care plan interventions. There was no analysis to determine how her incontinence affected her day to day life or if her incontinence could improve. d. Mood State CAA: under nature of condition was her age and diagnoses; under complications and risk factors was ineffective coping; under factors to consider were care plan interventions. There was no analysis of findings to determine how her mood was affected by her lack of coping skills in her day to day life or if her mood could	F 272		

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 10/28/2014

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 272	Continued From page 82 improve. e. Falls CAA: under nature of condition was her age and diagnoses; under complications and risk factors was the MDS information; under factors to consider were care plan interventions. There was no analysis to determine how falls affected her day to day life and if they could be prevented. f. Psychotropic drug use CAA: under nature of condition was her age and diagnoses; under complications and risk factors was potential for adverse side effects related to the use of psychotropic medications; under factors to consider were care plan interventions. There was no analysis to identify the reason for the psychotropic medications and the effects the medication had on her quality of life. Interview with the MDS coordinator on 10/16/14 at 1:47 PM revealed she completed all the MDS and CAAs in the building. As of a few weeks ago, other department heads started to complete different sections of the MDS. When completing a CAA, the MDS coordinator stated she looked at all the information gathered, talked to the resident and staff and read the documentation in the medical record. She stated the nature of the condition was the age and admitting diagnoses. The complication of the condition was what she was going to do for the resident. She further stated she had been trained that the CAA information had to match what the care plan interventions included. She then stated her consultant had read the CAA but never mentioned that information was missing. Per the MDS Coordinator, all the CAAs were written the same way with no analysis of the information just the repeat of a residents age, diagnoses, MDS information and care plan interventions.	F 272		
F 276	483.20(c) QUARTERLY ASSESSMENT AT	F 276		12/5/14

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 10/28/2014

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 276 SS=D	Continued From page 83 LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete quarterly assessments within the required time frame for 2 of 16 residents sampled for timeliness of quarterly assessments. (Residents #61 and #100). The findings included: 1. Resident #61 was admitted to the facility on 09/28/12. Review of the Minimum Data Sets (MDS) revealed the last annual MDS was dated 10/01/13. Resident #61 was discharged with return anticipated on 11/30/13 and reentered the facility on 12/23/14 at which time another quarterly MDS was completed. Quarterly MDSs were then completed on 01/30/14 and on 04/29/14. Interview with the MDS Coordinator on 10/17/14 at 12:37 PM revealed that she was unsure why she completed another quarterly assessment (in January) a month after the December quarterly MDS unless he had new physician orders that improved the reimbursement scores. Review of the submitted MDSs revealed Resident #61 was discharged with return anticipated on	F 276	1. Resident # 61 was not injured related to this citation. Resident #100 was not injured related to this citation. 2. All residents have the potential to be affected by this citation. An audit of current resident□s last two assessments, Minimum Data Set, was completed 11/10/2014-12/04/2014 by the Regional Case Mix Coordinator. 3. The Regional Case Mix Coordinator in serviced the Minimum Data Assessment Nurse, Director of Social Services, Activities Director, Dietary Director and the Director of Nursing and/or Nursing Supervisor on completion of the quarterly assessments within the required time frame 11/19/2014-11/20/2014. The Director of Clinical Services will perform Quality Improvement monitoring of the completion of the quarterly Minimum Data Set Assessments 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks and/or until substantial compliance is obtained. 4. The results of these audits will be	

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 10/28/2014

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 276	Continued From page 84 06/21/14, re-entered the facility on 07/03/14 and did not have another quarterly MDS until 08/16/14. During an interview on 10/16/14 at 1:47 PM, the MDS Coordinator stated that she was aware that when a resident was discharged with return anticipated, the time frames of the MDS's for quarterly and annual assessments did not change. She stated she had a system using a calendar to tract when assessments were due. On further interview on 10/16/14 at 2:38 PM, the MDS Coordinator stated that the facility consultants also kept tract of the timeliness of the MDSs and that she should have completed the last quarterly assessment prior to 08/16/14. 2. Resident #100 was admitted to the facility on 04/17/14. The admission Minimum Data Set (MDS) was dated 04/24/14. Resident #100 was discharged on 05/27/14 with return anticipated. She returned on 06/01/14. The next quarterly MDS was not completed until 08/16/14. During an interview on 10/16/14 at 1:47 PM, the MDS Coordinator stated that she was aware that when a resident was discharged with return anticipated, the time frames of the MDS's for quarterly and annual assessments did not change. She stated she had a system using a calendar to tract when assessments were due. On further interview on 10/16/14 at 2:38 PM, the MDS Coordinator stated that the facility consultants also kept tract of the timeliness of the MDSs and that she should have completed the quarterly assessment prior to 08/16/14.	F 276	reported to the Quality Assurance Performance Improvement Committee the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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 279	Continued From page 85	F 279		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to develop care plans that included measurable goals and individualized interventions for 8 of 28 sampled residents. (Residents #1, #11, #24, #34, #58, #68, #91, and #100). The findings included: 1. Resident #100 was admitted to the facility on 04/17/14. Her diagnoses included Parkinson's disease, history of traumatic brain injury, and	F 279	1. Resident #1 care plan and kardex was reviewed and updated 11/20/2014-11/26/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Activities). Resident #11 no longer resides at the facility. Resident #24 care plan and kardex was reviewed and updated 11/20/2014-11/26/2014 by the Interdisciplinary Team (Director of Clinical	12/5/14

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 10/28/2014

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

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F 279	Continued From page 86 dementia. Review of the Fall Investigation form revealed Resident #100 fell on 04/18/14 at 5:30 AM after she was sleeping and got out of bed to go to the bathroom. The supervisor report on the back of this form, dated 04/21/14, noted that the resident's care plan was updated to reflect the use of a bed and a chair alarm. An admission care plan originally dated 04/17/14 was updated to reflect a fall on 04/18/14 and the addition of a bed and chair alarm was to be used. The falls committee meeting notes dated 04/24/14 noted the plan for a bed and chair alarm. Interview with the Director of Nursing (DON) on 10/16/14 at 10:27 AM revealed the interdisciplinary team held a morning meeting daily which included discussion of falls that occurred. The DON confirmed that a chair and bed alarm was to be implemented following this fall and should have been care planned. The admission Minimum Data Set (MDS) dated 04/24/14 coded her with usually being understood and usually understands, having some inattention and disorganized thinking, having moderately impaired cognition (scoring a 10 out of 15 on the brief interview for mental status), requiring extensive assistance with bed mobility, transfers, toileting and limited assistance with ambulation. She was coded as needing assistance of staff to balance and being frequently incontinent of urine and weighing 210 pounds. The Care Area Assessments dated 04/30/14 stated falls, incontinence and weight would be care planned.	F 279	Services and/or Nursing Supervisor, Dietary Manager, Social Services, Activities). Resident #34 care plan and kardex was reviewed and updated 11/20/2014-11/26/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Activities). Resident #58 no longer resides at the facility. Resident #68 care plan and kardex was reviewed and updated 11/20/2014-11/26/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Activities). Resident #91 care plan and kardex was reviewed and updated 11/20/2014-11/26/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Activities). Resident #100 care plan and kardex was reviewed and updated 11/20/2014-11/26/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Activities). . 2. All residents have the potential to be affected by this citation. Current residents care plans and kardex were reviewed and updated if needed 11/24/2014-12/4/2014 by the Interdisciplinary Team (Director of	

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 10/28/2014

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 279	Continued From page 87 A. On 04/30/14 a comprehensive care plan was developed for the problem for potential for falls with a goal to remain free from falls through nursing interventions and prevention as evidence by no fall through 07/31/14. Interventions included: *keep adjustable bed in lowest position; *assist with transfers as needed; *keep call light and personal items in reach; *encourage resident to call for assistance; *encourage nonskid footwear; *keep clutter free environment; *monitor adverse side effects of medications; *therapy as indicated; and *provide appropriate safety devices as needed (wheelchair/walker). This care plan did not include the use of a bed and/or chair alarm. B. The care plan for incontinence dated 04/30/14 identified the problem for potential for urinary tract infections (UTIs) related to incontinence and the use of briefs. The goal was for the resident to remain free from signs and symptoms of UTIs as evidenced by no fever, chills, cloudy, concentrated, foul or strong smelling urine through 07/31/14. Care plan interventions included: *monitor for signs and symptoms of UTIs and report; *encourage fluids; *provide incontinent briefs per resident and family request; *provide pericare routinely and as needed; *assist with toileting as needed; and *monitor labs as ordered and notify physician of results. C. A care plan dated 04/30/14 for the problem of	F 279	Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Minimum Data Set Nurse, Activities). 3. The Regional Case Mix Coordinator in serviced the Minimum Data Assessment Nurse, Director of Social Services, Activities Director, Dietary Director and the Director of Nursing and/or Nursing Supervisor on completion of care plans or updating care plans with measureable goals with individualized interventions11/19/2014-11/20/2014. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of the completion/updating of the care plans for measurable goals with individualized interventions 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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 279	Continued From page 88	F 279		

potential for weight loss related to varied intake and diagnoses of dementia had a goal for the resident to maintain current nutritional status as evidence by no more than a 7.4% weight loss through 07/31/14. Interventions were:
*provide diet as ordered;
*assess meal intake, resident eats in her room and the main dining room;
*provide snacks per facility protocol;
*provide supplements as ordered;
*encourage good nutrition and hydration;
*dietician to evaluate as needed;
*monitor weights as ordered; and
*monitor labs as ordered and notify the physician of the results.

Interview on 10/16/14 at 1:47 PM with the MDS Coordinator revealed she was responsible for developing care plans based on the information she obtained from record review, other documentation and interviews with direct care staff. She stated that the care plans were incorporated into the computer system and she checked the intervention she wanted to use. Regarding the care plan for accidents for Resident #100, she stated that the last intervention which referred as "provide appropriate safety devices as needed (wheelchair/walker)" also meant alarms. She further stated that the care plans relating to the resident's falls, incontinence and weight were not individualized as the interventions on the care plan were selected from the computer's list.

2. Resident #58 was admitted to the facility on 09/03/14 with diagnoses including chronic respiratory failure, end stage chronic obstructive pulmonary disease, chronic pain, esophageal reflux, osteoporosis, anxiety and vitamin D

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 10/28/2014

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

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F 279	Continued From page 89	F 279		

deficiency.

The initial nursing assessment dated 09/03/14 noted she was admitted with excoriation to her buttocks and was a nonsmoker.

The admission Minimum Data Set (MDS) dated 09/12/14 coded her with intact cognitive impairment, limited assistance needed for most activities of daily living skills (ADLs), utilizing oxygen, receiving a mechanically altered diet and weighing 96 pounds being 5 feet 6 inches tall.

Review of the Care Area Assessments (CAA) dated 09/16/14 revealed care plans would be developed for the areas of potential for weight loss, potential for skin integrity issues, and the use of oxygen.

A. Resident #58 signed the facility's safe smoking rules on 09/03/14. Review of the undated Nurse Tech Information Kardex, used by nurse aides for individualized care revealed Resident #58 smoked and staff should ask the resident if she wanted to smoke at each smoke break per family request.

Review of Resident #58's care plans developed 09/16/14 revealed no care plan had been developed to address the resident's smoking.

B. The care plan dated 09/17/14 for the potential for skin integrity impairment related to decreased mobility had the goal for the skin to remain intact as evidence by no breakdown through 12/31/14. Interventions included:
*pressure reduction device to bed or chair as ordered;
*encourage frequent position changes and assist

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 10/28/2014

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 279	Continued From page 90	F 279		

as needed;
*weekly skin sweeps per hall nurse;
*Braden scale per policy schedule;
*provide treatments as ordered;
*encourage good nutrition and hydration; and
*monitor labs as ordered and notify physician of results.

The care plan did not address the existing excoriation that was being treated with physician orders.

c. The care plan dated 09/17/14 for the need of continuous oxygen and nebulizer treatments included the goal that the resident would maintain oxygen saturation ratings at 90% or above daily through 12/31/14. Interventions included:
*Administer oxygen as ordered
*monitor oxygen saturation ratings as ordered;
*change oxygen tubing weekly per facility protocol; and
*monitor for changes in symptoms that may indicate worsening respiratory status and report to the physician.

Review of the resident's physician orders revealed there were no orders to monitor Resident #58's oxygen levels.

D. The care plan for the potential for weight loss related to her receiving a mechanically altered diet and having varied intake had the goal for the resident to maintain her current nutritional status as evidence by no more than a 7.5% weight loss through 12/31/14. Interventions included:
*provide diet as ordered;
*assess meal intake, resident eats in her room and document;
*provide snacks per facility protocol;

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 10/28/2014

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 279	Continued From page 91	F 279		

*provide supplements as ordered;
*encourage good nutrition and hydration;
*dietician to eval as needed;
*monitor weights as ordered; and
*monitor labs as ordered and notify the physician of results.

Review of the resident's physician orders revealed there were no orders for nursing staff to monitor the resident's body weight.

Interview with MDS Coordinator on 10/16/14 at 1:47 PM revealed she was responsible for developing care plans based on the information she obtained from record review, other documentation and interviews with direct care staff. She stated that the care plans were incorporated into the computer system and she checked the intervention she wanted to use. She further stated that the resident's care plans were not individualized as the interventions on the care plan were selected from the computer's list. The MDS Coordinator stated she should have developed a smoking care plan for Resident #58 because she was aware the resident smoked. She stated the goal for the use of oxygen was not measurable if the oxygen saturation levels were not being checked. She also stated she did not address in the weight care plan Resident #58's underweight status.

3. Resident #24 was readmitted to the facility 06/21/13 with a diagnosis of history of stroke with left sided paralysis. A Minimum Data Set (MDS) dated 08/15/14 indicated the resident's cognition was intact. The MDS specified Resident #24 required extensive staff assistance bed mobility, transfers, toilet use, and personal hygiene, and was totally dependent on staff for bathing. The

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 279	Continued From page 92	F 279		

MDS further specified the resident had range of motion impairment in upper and lower extremities on one side.

A review was conducted of an Occupational Therapy Treatment Encounter Note dated 09/05/14. The document specified education was provided to the future restorative aide regarding how to stretch the resident's left upper extremity and how to apply a splint to the left hand. Further review revealed the resident was being prepared for discharge from therapy and was to be referred to restorative to prevent contractures in the resident's left hand and arm. The document further specified teaching range of motion techniques and application of splint to the restorative aide was completed with return demonstrations. The document was signed by the Certified Occupational Therapy Aide (COTA).

A review of a document dated 09/30/14 and entitled Therapy to Restorative Nursing Recommendations was conducted. The document provided instructions for range of motion and splint assist to upper extremity 4 to 6 hours. The form was signed by a former occupational therapist.

A review of Resident #24's current care plans revealed there was no care plan regarding the need for range of motion and application of a splint to the resident's left hand to prevent contractures.

An interview was conducted with the MDS Coordinator on 10/16/14 at 1:47 PM. She stated she was responsible for the care plans and that the care plans were developed based on areas of concern. She explained that she and the

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 10/28/2014

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 279	Continued From page 93	F 279		

Interdisciplinary Team collaborated to ensure the care plan was appropriate. She further explained the care plans were not individualized for each resident and that the care plan goals were developed to be realistic.

An observation and interview was conducted with Resident #24 on 10/17/14 at 8:35 AM. The resident was observed sitting in her wheel chair with her left arm hanging by her left side. Resident #24 picked up her left arm with her right hand and placed it on the wheel chair arm rest. The fingers on Resident #24's left hand were observed curled into the palm of the hand. Resident #24 straightened the curled fingers with her right hand. The resident stated she had a splint that was supposed to be applied to her left arm for several hours per day.

An additional interview was conducted with the MDS Coordinator on 10/20/14 at 11:34 AM. The MDS Coordinator confirmed Resident #24's left hand was at risk for contracture and the present care plan did not address this risk.

4. Resident #68 was admitted to the facility on 09/12/14 with diagnoses which included muscle weakness, chronic airway obstruction, osteoarthritis, anxiety, history of falls, and chronic pain. Resident #68's Annual Minimum Data Set (MDS) dated 09/23/14 revealed she was cognitively intact and was capable of making her needs known. The MDS further assessed the resident as needing limited assistance of one person for her activities of daily living (ADLs).

Review of Resident #68's medical record revealed there was no care plan available.

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 10/28/2014

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 279	Continued From page 94	F 279		

An interview was conducted with the MDS Coordinator on 10/15/14 at 10:58 AM. She indicated she was responsible for the comprehensive care plans for each resident. She stated the care plan for a resident was to be completed within 21 days of the resident's admission. She revealed Resident #68's care plan should have been completed on 10/03/14. She further stated, "She had not had a chance to get the care plan done in a timely manner."

An interview was conducted with the Director of Nursing (DON) on 10/15/14 at 3:02 PM. He stated he was unaware that staff had not developed a care plan for Resident #68 and the care plan was 12 days late. He further stated he expected the care plans to be completed on each resident within the 21 day time frame.

5. Resident #1 was readmitted to the facility on 10/12/13. Resident #1's diagnoses included but were not limited to schizophrenia, depressive disorder, high blood pressure, hyperlipidemia, and diabetes. Resident #1's medical record was reviewed and revealed the following nurse's entries:

- 12/07/13 resident refused shower
- 12/17/13 resident refused shower, mouth, and nail care

Resident #1's care plan updated on 06/30/14 for activities of daily living (ADLs) specified the "resident at times refuses to take showers." The care plan included a goal for which Resident #1 would demonstrate fewer episodes of shower refusal and interventions which included to provide showers per resident and family preferences, refer to shower schedule for Monday

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 10/28/2014

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 279	Continued From page 95	F 279		

and Thursday.

The most recent Minimum Data Set (MDS) dated 08/26/14 indicated the resident had severe cognitive impairment, was independent for bed mobility, transfer, ambulation, eating, and toileting, and the activity of bathing had not occurred and there was no assessment for assistance.

Further review of the medical record after the care plan was updated on 06/30/14 revealed an additional nurse's entry documenting refusal of showers included:

- 10/13/14 resident refused shower

Care plan interventions did not address that ADL care was needed for this resident or identified specifics which would cause this resident to refuse showers and/or ADL care.

Interview with the MDS Coordinator on 10/16/14 at 1:47 PM revealed she was responsible for the care plans. She indicated they used pre-developed care plans and the care plans were not individualized for each resident for ADLs. She stated if a resident's routine was different, the specifics would be noted on the resident's care plan. She confirmed that in the case of Resident #1 the care plan should have addressed the area of ADLs.

6. Resident #11 was admitted to the facility on 07/25/14 with the diagnoses which included dementia, cognitive/attention deficit, muscle weakness, lack of coordination, dehydration, and urinary tract infection. Resident #11's Admission Minimum Data Set (MDS) dated 08/01/14

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 10/28/2014

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 279	Continued From page 96	F 279		

revealed she had severe impaired cognition, requiring total dependence on staff with toileting, extensive assistance with bed mobility, transfers, dressing, eating, personal hygiene, and bathing.

Resident #11's medical record revealed the following nurse ' s notes regarding skin impairment:

- 07/29/14 sheered area to buttock
- 08/01/14 open area to coccyx
- 08/08/14 open area to buttock

Resident #11's care plan dated 08/08/14 contained a goal for skin integrity impairment specified the "resident will be free of further skin breakdown." Further review of the resident's care plan revealed it did not contain a goal that addressed the resident's actual skin breakdown.

Interview with the MDS Coordinator on 10/16/14 at 1:47 PM revealed she was responsible for developing and revising resident care plans and that the care plans were developed based on areas of concern. Resident #11's care plan goal for skin integrity impairment on 08/08/14 did not include a goal that addressed the resident's actual pressure ulcer skin impairment.

7. Resident #34 was readmitted to the facility on 10/29/13. Resident #34's diagnoses included but were not limited to schizophrenia, dementia, skin irritations, and dermatitis. Resident #34's medical record was reviewed and revealed the resident had a history of frequent falls. The record included the following entries:

- 07/14/14 resident found in floor of bathroom
- 07/21/14 resident found lying on his right side

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 10/28/2014

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

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F 279	Continued From page 97 in the floor - 08/25/14 resident fell out of bed onto his knees - 08/27/14 resident fell found in the floor - 09/25/14 resident fell found in the floor Resident #34's most recent Minimum Data Set (MDS) dated 08/01/14 specified the resident had severely impaired cognition and required extensive assistance with activities of daily living. The care plan updated 08/25/14 for potential for falls related to the use of psychotropic meds and diuretics contained the following goal "resident will remain free from falls through nursing interventions and preventions." Interview with the MDS Coordinator on 10/16/14 at 1:47 PM revealed she was responsible for the care plans and that the care plans were developed based on areas of concern. She explained that she and the Interdisciplinary Team (IDT) collaborated to ensure the care plan was appropriate. She further explained the care plans were not individualized. She stated she had not developed a care plan for accidents related to falls for Resident #34. 8. Resident #91 was admitted to the facility on	F 279		

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 10/28/2014

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

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F 279	Continued From page 98 07/07/14 with diagnoses of quadriplegia, coronary artery disease and hypertension. The admission Minimum Data Set (MDS) dated 07/14/14 indicated Resident #91 was cognitively intact. The MDS further indicated Resident #91 had range of motion (ROM) impairment for upper and lower extremities with resident and staff believing he was capable of increased independence in ROM. Review of Therapy to Restorative Nursing Recommendations dated 09/30/14 revealed Resident #91 was to receive ROM to his bilateral upper and lower extremities for 10 repetitions of each extremity and splints to the right hand and left elbow 4 to 6 hours per day. Review of Resident #91's care plan revealed no care plan was initiated for ROM to bilateral upper and lower extremities and splints to right hand and left elbow 4 to 6 hours per day. An interview was conducted on 10/17/14 at 9:47 AM with the Minimum Data Set (MDS) Coordinator. She reported she did not do a ROM and splint care plan until she was notified by the Restorative Aide that the resident had been referred to Restorative Nursing. She stated she had not been notified that Resident #91 had been referred to Restorative Nursing. An interview was conducted on 10/21/14 at 11:30 AM with the Director of Nursing. He stated the Restorative Nursing Program was in the process of being revised by himself and the Assistant Director of Nursing. He reported Resident #91's care plan referral had not been brought to the care plan meeting because there was no restorative program at the time of the referral. He stated Resident #91 should have been care planned for ROM and splints.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		12/5/14

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 99 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to update care plans to reflect new interventions for 2 of 2 sampled residents (Residents #100, #24) reviewed for updated care plans and failed to include 1 of 3 sampled families (Resident #57) to the care plan meetings. The findings included: 1. Resident #100 was admitted to the facility on 04/17/14. Her diagnoses included Parkinson's disease, history of traumatic brain injury, dementia, gastroesophageal reflux,	F 280	1. Resident #24 care plan was reviewed and updated 11/20/2014-11/26/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Minimum Data Set Nurse, Social Services, Activities). Resident #100 care plan was reviewed and updated 11/20/2014-11/26/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Minimum Data Set Nurse, Social Services, Activities).	

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 100 hypothyroidism and hyperlipidemia. The admission Minimum Data Set (MDS) dated 04/24/14 coded her with usually being understood and usually understands, having some inattention and disorganized thinking, having moderately impaired cognition (scoring a 10 out of 15 on the brief interview for mental status), requiring supervision and set up for eating, having a poor appetite or overeating nearly every day, having no behaviors, and weighing 210 pounds at 5 feet 6 inches tall. A care plan was developed on 04/30/14 for the problem of potential for weight loss related to varied intake and diagnosis of dementia. The goal was for Resident #100 to maintain current nutritional status as evidenced by no more than a 7.4% weight loss through the next review. Interventions included to provide diet as ordered, assess meal intake and document, resident eats in her room, provide supplements as ordered, encourage good nutrition and hydration, dietician to eval as needed, monitor weights as ordered and monitor labs as ordered. Per Resident #100's weight record, on 05/06/14 she weighed 211.4 pounds and on 06/05/14 she weighed 190.6 pounds (a one month 9.84% significant weight loss). The RD noted on 06/23/14 that she had a 9.8% wt loss in one month. The notation stated that weight loss would be beneficial to the resident at a slower rate and at adequate intake. The RD noted recommendations for a fortified meal plan and to monitor weight and intake and follow up as needed. No changes were made to the nutritional care plan goal or the intervention to	F 280	Resident #57 care plan was reviewed and updated with family via telephone 10/20/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Minimum Data Set Nurse, Social Services, Activities). 2. All residents have the potential to be affected by this citation. Current residents care plans were reviewed and updated if needed 11/24/2014-12/4/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Minimum Data Set Nurse, Activities). 3. The Regional Case Mix Coordinator in serviced the Minimum Data Assessment Nurse, Director of Social Services, Activities Director, Dietary Director and the Director of Nursing and/or Nursing Supervisor on completion of care plans or updating care plans with measureable goals with individualized interventions during the morning clinical meeting by the minimum data assessment nurse and the Director of Clinical Services, and to include the resident and families in the care plan meetings 11/19/2014-11/20/2014. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of the completion/updating of the care plans for measurable goals with individualized interventions 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks and/or until substantial	

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 101 include fortified foods. Per Resident #100's weight record, her weight continued to drop as documented on 07/07/14 when she weighed 185.8 pounds. Resident #100 was seen for Speech Therapy (ST) from 06/03/14 through 07/13/14. Review of the ST discharge summary revealed the resident met the goals of consuming at least 50% for at least 2 meals for 5 consecutive days to prevent malnutrition and weight loss and to improve task recognition to 90% during therapeutic opportunities to prevent malnutrition and weight loss on 07/13/14. Discharge recommendations included for caregivers to set up resident at meals and the resident is to dine in the main dining room at meals. Interview with the ST on 10/16/14 at 1:25 PM revealed that she worked with Resident #100 in order to increase the resident's intake. ST stated the breakfast meal was her worst meal for consumption and at times, she needed to sit with her, feed her and give her lots and lots of encouragement to eat. She stated Resident #100 consumed the best when she ate in the dining room which was shy she recommended her to eat in the dining room as often as she would agree to go. Again the care plan was not updated to include the interventions to encourage her to eat in the main dining room or that she should eat 50% of each meal. Per Resident #100's weight record, her weights continued to drop as documented on 08/12/14 when she weighed 177.4 pounds (weight loss of	F 280	compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor, Executive Director will perform Quality Improvement monitoring of the Care Plan Invitation to families and residents with follow up calls to families 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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

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F 280	Continued From page 102	F 280		

4.5 % in one month and 16.08% in 3 months).

The Director of Nursing provided weight committee notes dated 08/13/14 which indicated that she received a regular diet with fortified foods and was within her ideal body weight range. The corresponding interdisciplinary note dated 08/13/14 included plans to add ice cream and/or pudding to lunch and dinner trays. In addition the plan was to educate the resident about maintaining her current weight. No changes were made to the care plan.

Resident #100's weight record noted her weight on 09/04/14 as 173.4 pounds (a loss of 9% in 3 months - since 06/05/14).

On 09/08/14 the RD noted a 9% weight loss in 3 months. He noted she was on an fortified meal plan and ate approximately 50%. The RD recommended a house supplement 60 cc 4 times per day and follow up as needed. This was written on a recommendation form which was dated 09/08/14. The physician's order was not written for the house supplement until 09/21/14 and the house supplement was not started per the Medication Administration Record until 09/22/14.

Review of the nutritional care plan on 10/15/14 revealed the interventions had not changed to include, ice cream, fortified foods or the supplement or any changes in the goal.

Interview with DON on 10/17/14 at 2:45 PM, revealed the facility had weekly weight committee meetings to discuss residents. He stated the RD left him and the dietary manager recommendations of those residents reviewed.

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 103	F 280		

He stated that at the weight committee meetings, the team had the RD's recommendations and the chart to ensure all recommendations were acted upon and the care plan updated.

Per Resident #100's weight record, her weight continued to drop as documented on 10/12/14 at 167.8 pounds (20% significant weight loss in 6 months).

2. Resident #24 was readmitted to the facility 06/21/13 with diagnoses which included history of stroke with left sided paralysis, dysphagia, and esophageal reflux disease.

A care plan updated 06/04/14 described Resident #24 had a potential for weight loss related to a mechanically altered diet. The care plan goal specified the resident would not experience more than a 7.5% weight loss in the next 3 months. Interventions included provide diet as ordered, encourage resident to take small bites and sips and alternate bites and sips, and resident to be at a 90 degree angle during meals.

A review of Resident #24's medical record revealed an order initiated by a Speech Therapist (ST) dated 06/15/14. A fluoroscopic swallow study (examination of swallowing function that uses a special x-ray) was recommended to determine the least restrictive diet level related to the resident's dysphagia.

Continued medical record review revealed a report from the swallow study. The report was dated 06/24/14 and signed by a Speech-Language Pathologist from the hospital. The safe feeding and diet recommendations included one-to-one supervision with eating. The

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 10/28/2014

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

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F 280	Continued From page 104	F 280		

one-to-one supervision was circled and was listed on the first line of the report. A hand written note on the swallow study report specified the recommendations were noted and dated 06/24/14 by Nurse #8.

Additional medical record review revealed a physician's telephone order dated 06/24/14. The order was written as a diet clarification for Resident #24. The order contained the diet recommendations from the swallow study report, but excluded one-to-one supervision with eating. The clarification order was signed by the facility physician and noted by Nurse #8.

Continued care plan review revealed the last updated intervention on the care plan was dated 06/26/14. This update included diet clarifications for mechanical soft, finely chopped soft solids, ground meats, and regular thin liquids. Interventions did not include one-to-one supervision with eating. The care plan did not specify the resident required one-to-one supervision with meals or identify the resident as an aspiration risk.

A quarterly Minimum Data Set (MDS) dated 08/15/14 indicated the resident's cognition was intact. The MDS specified the resident required extensive staff assistance with all activities of daily living except for eating which required supervision. The MDS further specified the resident had no choking with meals and was on a mechanically altered diet.

An interview was conducted with the MDS Coordinator on 10/20/14 at 11:34 AM. She reviewed Resident #24's care plan and was unable to find any mention of the resident being

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 10/28/2014

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

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F 280	Continued From page 105	F 280		

at risk for aspiration. The MDS Coordinator stated she got a copy of all physician orders. She stated the one-to-one supervision was not on the copy of the telephone order dated 06/24/14 and she was unaware of the resident's risk for aspiration.

An interview was conducted with Nurse #8 on 10/21/14 at 3:26 PM. Nurse #8 confirmed she wrote and noted the diet clarification telephone order from the swallow study report. She stated she overlooked the one-to-one supervision that was circled at the top of the swallow study recommendation report. Nurse #8 added the resident did eat all meals in the main dining room.

3. Resident #57 was admitted to the facility on 06/15/12 with diagnoses including dementia. The quarterly Minimum Data Set (MDS) dated 07/04/14 revealed Resident #57 had severely impaired cognition.

During an interview on 10/13/14 at 11:30 AM Resident #57's family member stated he had not been invited by the facility to participate in Resident # 57's quarterly care planning conferences and did not recall participating in a care plan conference.

Review of Resident # 57's care conference record revealed care conferences for Resident #57 were conducted on 03/02/14, 06/18/14, and 07/09/14 and were attended by the Minimum Data Set (MDS) Coordinator and the Dietary Manager.

Review of documentation for the care planning conferences on 03/02/14, 06/18/14 and 07/09/14 revealed the MDS Coordinator documented the family member and resident had declined the

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 106 invitation to attend. An interview was conducted with the MDS Coordinator on 10/16/14 at 1:35 PM. The MDS Coordinator stated she mailed the invitation for the quarterly care plan conference to the residents' family member 7 to 10 days before the conference date. The family member was informed of the date of the care plan conference in the letter and asked to call the facility to set up an appointment time. The MDS Coordinator further stated she did not keep a copy of the invitations and did not follow up with the family members after the invitation was mailed. When asked specifically about Resident #57's family member the MDS Coordinator stated the family member probably did not respond to the invitation for the care plan conferences conducted on 03/02/14, 06/18/14 , and 07/09/14 and she did not follow up after the invitation was sent.	F 280		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to provide restorative services to 1 of 2 sampled residents (Resident #100) referred from therapy to maintain transfer and ambulation abilities. The findings included:	F 311	1. Resident #100 was assessed by the physician on 11/18/2014 with new orders noted. A permanent restorative aide was put into place by 12/1/2014. 2. Residents that need to participate in a Restorative Program have the potential to	12/5/14

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

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 311	Continued From page 107 Resident #100 was admitted to the facility on 04/17/14. Her diagnoses included Parkinson's disease, history of traumatic brain injury, dementia, gastroesophageal reflux, hypothyroidism and hyperlipidemia. The admission Minimum Data Set (MDS) dated 04/24/14 coded her with usually being understood and usually understanding, having some inattention and disorganized thinking, having moderately impaired cognition (scoring a 10 out of 15 on the brief interview for mental status), requiring extensive assistance with bed mobility, transfers, toileting and limited assistance with ambulation in room, hygiene and dressing. She was coded as needing assistance of staff to balance. This MDS coded her as receiving Occupational and Physical therapies. The quarterly MDS dated 08/22/14 coded her with usually being understood and usually understanding, having some inattention and disorganized thinking, having moderately impaired cognition (scoring a 9 out of 15 on the brief interview for mental status), requiring extensive assistance with bed mobility, transfers and only ambulating once or twice in previous 7 days. She was coded as receiving Physical Therapy. Review of the medical record with the physical therapy aide (PTA) on 10/15/14 at 2:25 PM revealed he worked with Resident #100 several different times on transfers and coordination. The medical record revealed she was seen by physical therapy from 04/17/14 through 05/27/14; from 06/02/14 to 07/30/14; and most recently from 08/05/14 through 09/24/14. PTA stated that Resident #100 would reach her maximum	F 311	be affected by this citation. An audit of current residents needing restorative nursing was completed by the Director of Clinical Services 11/21/2014-12/1/2014. 3 The Director of Clinical Services and/or Nursing Supervisor in serviced certified nurse assistant on the restorative nurse program 11/24/2014-12/1/2014. This includes providing restorative nursing IE splint application, range of motion, maintain ambulation and transfers as outlined in the therapy to nursing communication plan. Therapy trained certified nurse assistant on providing a restorative program 11/24/2014-12/1/2014. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of the residents that participate in the restorative program 3 times a week for 2 month, 2 times a week for 2 months, 1 time a week for 2 and/or until substantial compliance is obtained. 4 The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data	

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 311	Continued From page 108 potential or would want to stop participating. Review of the Physical Therapy Discharge Summary dated 09/26/14 revealed the last time services ended was on 09/24/14. At the time of discharge, the therapy notes revealed Resident #100 had improved from her baseline of requiring moderate assistance to transfer to needing contact guard and improved from her baseline of requiring minimal assistance to ambulate 6 feet to needing minimal assistance and ambulating 40 feet. The discharge prognosis stated the resident met her level of maximum potential and was to continue with restorative care to maintain level of function. The PTA provided the surveyor with a form "Therapy to Restorative Nursing Recommendations" dated 09/17/14. This form noted the recommended programs included: a. range of motion to be done to both lower extremities to include marching, ham curls hip abduction and hip adduction exercises with 1 set of 20 repetitions with 2 pound weights; and b. transfer training with the minimum assistance of 1 aide and a 2 wheeled walker. This form indicated a specifically named restorative nursing staff was trained on the program on 09/17/14. On 10/15/14 at 11:18 AM, Nurse Aide (NA) #4 and NA #5 were observed transferring this resident from her bed into her wheelchair. Each NA supported her under her arms as she pivoted into the wheelchair. NA #4 stated that Resident #100 normally needed 1 person assistance but that lately she required 2 person assist as she was more "wobbly.'	F 311	Assessment Nurse.	

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 10/28/2014

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 311	Continued From page 109	F 311		

Interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 10/15/14 at 3:10 PM revealed they were just getting the restorative program off the ground. They further stated they had been training a restorative aide, however, she recently notified them that she was quitting her employment with the facility so they had to start from scratch with a restorative program. They stated they had yet to develop policies and procedures for the restorative program. In the meantime, the DON stated he expected the floor nurses to be responsible to ensure restorative services were provided and document such in the Medication Administration Record (MAR).

On 10/20/14 at 4:25 PM NA #11 who was caring for Resident #100 this date stated she normally worked on a different hall and was unaware of any need to provide ambulation or range of motion to her. She further stated that Resident #100 "barely walked."

Interview with NA #5 on 10/21/14 at 8:50 AM revealed she pushed the resident in her wheelchair into the bathroom or by the sink at which point the resident held on to the bar and assisted in standing. NA #5 stated she did not provide ambulation or range of motion exercises to Resident #100.

Interview with Nurse #4 on 10/21/14 at 8:53 AM revealed that the restorative aide was responsible for ambulation and range of motion for residents. She stated that nurses or nurse aides could provide the service if there was not a restorative aide. Nurse #4 stated she had not provided restorative services to Resident #100.

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 311	Continued From page 110 Review of the MAR for September or October 2014 revealed no documentation that restorative services were provided. On 10/21/14 at 9:03 AM, the DON and ADON stated they were unaware that Resident #100 had been referred to the restorative program for ambulation and range of motion. The DON stated that the facility did not have a restorative program and it had not been established yet. He stated the nurses were responsible for providing restorative services.	F 311		
F 312 SS=E	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 observations, record reviews, and staff and resident interviews the facility failed to provide repositioning every 2 hours, showers and getting out of bed in the morning as requested, wipe from front to back during incontinence care, provide bed baths between showers, and trimming of toenails for 4 of 11 residents reviewed for activities of daily living. (Residents #91, #60, #67, and #89). The findings included: 1. Resident #91 was admitted to the facility on 07/07/14 with diagnoses of quadriplegia, coronary artery disease and hypertension. The admission Minimum Data Set (MDS) dated 07/14/14	F 312	1. Resident # 91 was not injured related to this citation. Resident #91 preferences for getting up was gotten 11/17/14-11/20/2014. Resident # 60 was not injured related to this citation. Resident #60 preference for showers was gotten 11/17/2014-11/20/2014. Resident #67 was not injured related to this citation. Resident #67 preference for showers was gotten 11/17/2014-11/20/2014. Resident # 89 was not injured related to this citation. Resident #89 had nail care	12/5/14

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 111 indicated Resident #91 was cognitively intact. The MDS further indicated Resident #91 was dependent for bed mobility and transfers and was admitted to the facility with 3 stage 2 pressure ulcers. Review of Resident #91's care plan dated 07/23/14 revealed he had potential for skin integrity impairment related to decreased mobility and was admitted with pressure areas to the left coccyx and left iliac crest. Interventions included pressure reducing device to the bed and chair, frequent position changes and assist as needed, weekly skin sweeps per hall nurse, provide treatment as ordered, monitor labs as ordered and notify doctor of results, provide supplements as ordered. An interview was conducted on 10/15/14 at 2:30 PM with Resident #91. He stated he was not turned and repositioned every 2 hours and he had to wait to get up in the mornings for the nurse aide (NA) to find help from another hall to get him out of bed. An interview was conducted on 10/20/14 at 12:09 PM with Nurse Aide (NA) #2. She stated she had worked at the facility a year and a half and had always worked the 7:00 AM to 3:00 PM shift on the 100 hall. She stated she was the only NA on the 100 hall for 9 skilled nursing residents. NA #2 stated it was very difficult to get all resident care done by herself due to having 3 residents that required feeding assistance and 2 total lift residents. She reported when she was feeding a resident she can't get up to answer call lights and when she had to get the 2 total lift residents out of bed she had to leave the hall to find someone to help her. She further stated she was not able to get Resident #91 turned and repositioned every 2 hours and had to wait for help from another hall before she could get him out of bed.	F 312	on 10/16/2014 by licensed. NA #3 was in serviced on peri care and providing bed baths on 11/19/2014 by the Director of Clinical Services. NA #5 was in serviced on peri care and providing bed baths on 11/19/2014 by the Director of Clinical Services. 2. All residents have the potential to be affected by this citation. The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) interviewed residents and/or their responsible parties for shower preferences and get up times. Observation of residents toe nails was completed 11/20/2014-11/24/2014 by the licensed nurse to identify nails that required care. An audit of residents who require turning every two hours care plans was completed 11/20/2014-11/28/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Minimum Data Set Nurse, Activities). Observations of peri care were completed 11/19/2014-11/28/2014 by the Director of Clinical Services and/or Nursing Supervisor. 3. Certified Nurse Assistants, Licensed Nurses were in serviced by the Director of Clinical Services and/or Nursing Supervisor on providing showers per resident preference, providing bed baths on other days and observing and reporting	

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 10/28/2014

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

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F 312	Continued From page 112 An interview was conducted on 10/20/14 at 11:19 AM with the Director of Nursing (DON) and the Administrator. They stated they were not aware there was only 1 NA on the 100 hall and stated there should have been 2 NAs or a floater to help on the 100 hall. The DON stated it was his expectation that all residents with orders for turning and repositioning every 2 hours be turned and repositioned as ordered and residents gotten out of bed as they desire. 2. Resident # 60 was readmitted to the facility 08/15/14 with diagnoses which included urinary tract infection, debility, and congestive heart failure. A Care Area Assessment (CAA) dated 08/22/14 specified Resident #60 was dependent on staff assistance for bathing. The CAA further stated showers would be provided per resident requests and desired shower frequency was documented on the shower schedule. A Care Plan dated 08/27/14 identified Resident #60 as dependent on staff for bathing. The care plan goal specified the resident's activities of daily living needs would be met through nursing interventions for the next 90 days. Interventions included provide assistance with activities of daily living as needed and provide showers per resident and family preferences, see shower schedule. A quarterly Minimum Data Set (MDS) dated 09/28/14 indicated the resident's cognition was intact. The MDS specified Resident #60 required extensive staff assistance for bed mobility, dressing, and toilet use and was dependent on staff to provide bathing and transfers. The MDS	F 312	residents requiring nail care, and turning residents that require frequent turning and proper peri care11/10/2014-12/4/2014. The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement monitoring of 2 certified Nurse Assistant providing peri care each shift 5 times a week for 1 month, 3 times a week for 1e month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of residents requiring frequent repositioning 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. Director of Clinical Services and/or Nursing Supervisor will perform audit of residents receiving showers and/or bed baths for honoring of preferences 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 1 month and 1 time a week for 1 month and/or substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of residents requiring frequent repositioning 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of 10 residents	

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 10/28/2014

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

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F 312	Continued From page 113 further specified the resident had an indwelling urinary catheter. A review of an undated shower schedule revealed Resident #60 was assigned showers Monday on the 3:00 PM to 11:00 PM shift and Wednesday and Saturday on the 7:00 AM to 3:00 PM shift. A review of a staff assignments dated 10/11/14 revealed Nurse Aides (NA) #12 and #13 worked the day shift on 10/11/14 on Resident #60's hall. The staff assignment sheet dated 10/13/14 revealed NAs #11 and #14 worked the evening shift on the resident's hall. An interview with Resident #60 on 10/12/14 at 3:30 PM revealed she did not get a shower on Saturday. The resident stated she was supposed to get 3 showers a week on Monday, Wednesday, and Saturday. She added on Wednesday and Saturday she got showers on the day shift. Resident #60 stated on Saturday, 10/11/14, she did not get a shower. She added staff did not offer a shower to her. They just didn't come get her for her shower. Resident #60 stated it was not unusual for the staff to forget her shower on Saturday. An additional interview with Resident #60 on 10/14/14 at 4:51 PM revealed she did not get a shower on Monday evening, 10/13/14. The resident stated NA #11 came into her room around super time to report there were no other nurse aides available now to assist with a shower. The resident added NA #11 stated she was going to communicate with another nurse aide that worked the evening shift the following day to ask if the resident could be worked into her shower schedule on Tuesday. The resident stated she	F 312	toe nails 3 times a week for eight weeks, 2 times a week for eight weeks, 1 times a week for eight weeks and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of clinical services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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 312	Continued From page 114	F 312		

had not had a shower since the previous Wednesday and she should be getting 3 showers per week.

An interview was conducted with NA #12 on 10/15/14 at 9:39 AM. NA #12 stated she did not come to work on 10/11/14 until 12 noon and she was assigned to care for Resident #60. NA #12 acknowledged NA #13 had worked since 7:00 AM and was her partner on Resident #60's hall. NA #12 stated NA #13 reported to her when she arrived at noon that all showers were done. NA #12 explained she had talked with Resident #60 who reported she was not feeling well. NA #12 stated she assumed Resident #60 had refused a shower and NA #13 had reported that to the nurse. NA #12 explained the NAs were expected to offer residents a shower. If the resident refused, the NA was expected to go back as many as 3 times to offer a shower. If the resident refused all 3 offers, the NA was expected to report the refusal to the nurse. NA #12 repeated after NA #13 reported to her all the showers were done, she did nothing further concerning showers on that Saturday.

An interview was conducted with NA #13 via phone on 10/15/14 at 10:21 AM. NA #13 stated she worked at this facility as needed. She stated she did not offer or provide a shower for Resident #60 when she worked at the facility on Saturday, 10/11/14. NA #13 added when she worked at this facility, she just looked at the assignment sheet and was unaware of what days Resident #60 got showers.

An interview was conducted with NA #11 on 10/15/14 at 4:16 PM. NA #11 stated Resident #60 did not get a shower the evening of Monday

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 10/28/2014

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 312	Continued From page 115	F 312		

10/13/14. NA #11 stated her partner on Resident #60's hall was NA #14. She explained NA #14 reported to her that Resident #60 had refused her shower. NA #11 stated she had not known Resident #60 to refuse a shower and went to talk with the resident. She stated Resident #60 did want a shower but had not been asked. NA #11 reported NA #13 went on brake and returned to the hall around 8:30 PM then went home ill. NA #11 stated there was no one to assist her with Resident #60's shower until around 9:30 PM and that was too late for the resident. She stated Resident #60 asked if she could be showered on the following morning, Tuesday 10/14/14. NA #11 stated she passed that on to night shift nurse aides assuming they would pass it on to the day shift. NA #11 explained the procedure for shower refusals was the nurse aide was supposed to document the refusal on a shower sheet and hand it into the nurse at the end of the shift. NA #11 did not notify the nurse.

An interview with the Director of Nursing (DON) on 10/16/14 at 8:25 AM revealed he placed residents' names on the shower schedule per the residents' request. He stated he expected nurse aides to encourage the resident however many times it took to get residents to take showers. If the resident continued to refuse, the nurse aides should report the refusal to the nurse. The DON added that he expected the nurse to investigate the refusal and prompt the resident to take a shower.

An interview was conducted with NA #13 via phone on 10/16/14 at 11:33 AM. NA #13 stated she recalled on Monday evening of 10/13/14 around 7:00 PM asking Resident #60 if she was ready for her shower. She stated the resident

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 10/28/2014

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 312	Continued From page 116	F 312		

refused then because of nausea and stated she would take her shower around 8:30 or 9:00 PM. NA #13 stated the nurse aides got busy putting other residents to bed and were not free to provide a shower for Resident #60 at the time requested. NA #13 stated she did not let the nurse know Resident

3. a. Resident #67 was admitted to the facility on 04/23/14 with diagnoses which included high blood pressure, diabetes, depression and a stroke. A review of the most recent quarterly Minimum Data Set (MDS) dated 07/29/14 indicated Resident #67 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #67 required extensive assistance by staff for personal hygiene and was totally dependent on staff for bathing and was incontinent of bladder and bowel.

A review of a care plan updated on 09/21/14 indicated a problem statement for potential for urinary tract infections related to incontinence and use of briefs. The goals indicated Resident #67 would remain free from signs or symptoms of urinary tract infections and interventions were listed in part to assist with toileting as needed and provide peri care routinely and as needed.

During an observation of incontinence care on 10/16/14 at 10:20 AM Nurse Aide (NA) #3 and NA #5 removed a wet brief from Resident #67 that contained a large amount of stool. Resident #67 was turned to his right side and NA #5 wiped Resident #67's buttocks with wash cloths that appeared to be wet but stated "it's not coming off." NA #3 removed her gloves and washed her hands and stated she was going to get 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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 312	Continued From page 117	F 312		

wash clothes. At 10:25 AM NA #3 re-entered the room with more washcloths and a bottle of peri wash and NA #5 used the peri wash and washcloths to wipe stool off Resident #67's buttocks. Resident #67 was then turned to his back and NA #5 wiped stool from between Resident #67's groins from back to front and cleaned his penis with the same washcloth without turning it over.

During an interview on 10/16/14 at 10:45 AM NA #5 verified she wiped inside Resident #67's groins from back to front and stated she realized she wiped in the wrong direction and she should have used a clean washcloth to clean his penis.

During an interview on 10/21/14 at 12:15 PM the Director of Nursing stated it was his expectation for staff to follow the facility policy and clean a resident during incontinence care from front to back and to use peri wash or soap and water. He further stated it was his expectation for staff to change the washcloth when it was soiled or turn the washcloth over to prevent contamination.

b. Resident #67 was admitted to the facility on 04/23/14 with diagnoses which included high blood pressure, diabetes, depression and a stroke. A review of the most recent quarterly Minimum Data Set (MDS) dated 07/29/14 indicated Resident #67 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #67 required extensive assistance by staff for personal hygiene and was totally dependent on staff for bathing and was incontinent of bladder and bowel.

A review of a care plan with latest review date of

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 10/28/2014

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 312	Continued From page 118	F 312		

08/31/14 indicated a problem statement in part for activities of daily living (ADL) deficits and extensive assistance with dressing, personal hygiene and total assistance with bathing. The goals indicated Resident #67's ADLs would be met through nursing interventions and resident participation as evidenced by resident would remain clean and neat and dressed in appropriate clothing daily. The approaches were listed in part to provide assistance with ADLs as needed.

During an observation on 10/16/14 at 10:20 AM Nurse Aide (NA) #5 and NA #3 provided incontinence care to Resident #67 and placed a clean brief on him. NA #5 then wiped Resident #67's face with a wet washcloth then NA #5 and NA #3 took Resident #67's gray t-shirt off and put a blue t-shirt on him but did not wash under his arms or his upper body or back. Resident #67 had on a pair of blue socks but NA #5 and NA #3 did not remove the socks and did not wash his feet or wash his lower legs. They pulled a sheet up over Resident #67, removed their gloves and washed their hands and left the room.

During an interview on 10/16/14 at 10:45 AM with NA #3 she stated she had not been in Resident #67's room that morning prior to his incontinence care and had not provided any other AM care to the resident. She further stated Resident #67 was supposed to get a shower twice a week. She explained residents usually only received a bed bath between showers if they were soiled and confirmed they did not give Resident #67 a bed bath after they provided incontinence care.

During an interview on 10/16/14 at 11:00 AM with NA #5 she stated she had only worked in the facility for 2 weeks. She stated during the time

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 10/28/2014

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 312	Continued From page 119	F 312		

she had worked in the facility she had not seen bed baths given in between shower days unless the resident was obviously soiled or the resident requested it. She further stated the care they gave Resident #67 that morning was their usual routine for AM care

During an interview on 10/21/14 at 12:15 PM the Director of Nursing stated it was his expectation for staff to bathe residents in between their shower days and he expected for staff to change residents clothing during morning care.

4 a. Resident #89 was admitted on 09/26/14 with diagnoses including cancer, debility, anemia, and recent history of sepsis. The admission Minimum Data Set (MDS) dated 10/03/13 revealed Resident #89 was cognitively intact and was able to make her needs known. The admission MDS noted Resident #89 required one person physical assistance with personal hygiene.

Review of a nursing admission assessment dated 09/26/14 revealed Nurse #6 documented Resident #89 had long, thick toenails on both feet. Nurse #5 also circled the toes on the picture of the feet on the admission assessment and indicated next to the picture her toenails were long.

Review of the Care Area Assessment (CAA) Summary for activities of daily living (ADL) dated 10/04/14 noted Resident #89 had an ADL deficit due to diagnoses of cancer, debility, depression, and anxiety. The CAA summary stated Resident #89 required limited assistance of one person with personal hygiene.

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 10/28/2014

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 312	Continued From page 120	F 312		

Review of a care plan for ADL deficit dated 10/08/14 revealed Resident #89 required limited assistance of one person for personal hygiene. The intervention was for staff to provide the resident with ADL assistance as needed.

An observation of Resident #89's toe nails on 10/13/14 at 11:17 AM revealed all ten toenails were thick and extended approximately ¼ of an inch past the end of her toes. Resident #89 stated she had mentioned to a staff member her toenails needed to be trimmed but she could not recall what they told her.

A subsequent observation of Resident #89's toe nails on 10/16/14 at 8:30 AM revealed all ten toenails were thick and extended approximately ¼ of an inch past the end of her toes.

During an interview on 10/16/14 at 8:30 AM Resident #89 stated a nurse had told her she was going to trim her toenails on 10/15/14 if she had a chance. Resident #89 further stated she had a clipper to trim her toenails with but could not reach to trim them herself.

An interview with Nurse Aide (NA) #3 on 10/16/14 at 8:36 AM revealed NAs could trim resident's fingernails and toenails and she typically completed this task with the resident's shower. NA #3 explained NAs did not trim nails if the resident was a diabetic and if a resident's toenails were thick they informed the nurse so the resident could be placed on the list for the Podiatrist.

During an interview on 10/16/14 at 10:04 AM Nurse #6 stated she completed head to toe assessment when she admitted a resident 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 10/28/2014

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 312	Continued From page 121	F 312		

included the condition of their feet and toenails in her documentation on the nursing admission assessment. Nurse #6 further stated nurses could trim resident's toenails but if the toenails were thick they would need a referral to be seen by the Podiatrist. Nurse #6 recalled admitting Resident #89 and stated she did not make a notation on the 24 hour nursing report regarding the condition of her toenails or put her on the list to be seen by the Podiatrist. The interview further revealed Nurse #6 expected the nurse who rounded with the physician to review the admission assessment and inform him of any concerns including long thick toenails.

On 10/16/14 at 9:37 AM the Director of Nursing (DON) observed Resident #89's toenails and agreed they needed to be trimmed.

An interview with the DON on 10/20/14 at 4:42 PM revealed he expected nurses and NAs to trim resident's toenails unless they were thick, brittle or the resident was a diabetic. The DON stated diabetic residents and/or residents with thick, brittle toenails should be referred to the Podiatrist. The interview further revealed new admission medical records were reviewed during weekday morning meetings to make sure there were not any issues that needed to be addressed. The DON did not recall any mention of the condition of Resident #89's toenails during a morning meeting.

b. Resident #89 was admitted on 09/26/14 with diagnoses including cancer, debility, anemia, and recent history of sepsis. The admission Minimum Data Set (MDS) dated 10/03/13 revealed Resident #89 was cognitively intact and was able to make her needs known. The admission MDS

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 10/28/2014

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 312	Continued From page 122	F 312		

noted Resident #89 required one person physical assistance with bathing and bathing did not occur during the 7 day look back period.

Review of a resident preference list dated 09/26/14 revealed Resident #89 requested 2 showers a week.

Review of the facility's computer generated activities of daily living (ADL) report for Resident #89 dated 09/26/14 through 10/14/14 revealed she had showers documented on 10/04/14 and 10/06/14.

Review of the Care Area Assessment (CAA) Summary for activities of daily living (ADL) dated 10/04/14 noted Resident #89 had an ADL deficit due to diagnoses of cancer, debility, depression, and anxiety. The CAA summary stated Resident #89 required limited assistance of one person for bathing hygiene.

Review of a care plan for ADL deficit dated 10/08/14 revealed Resident #89 required limited assistance of one person with personal hygiene. The intervention was for staff to provide the resident with ADL assistance as needed and provide showers per the resident and family request. The ADL care plan did not include refusal of care

Review of the shower schedule utilized by nurse aides (NA) revealed Resident #89 was scheduled for showers on Wednesday and Saturday on the 7:00 AM to 3:00 PM shift.

Review of nurse's notes from 09/26/14 through 10/14/14 revealed no documentation of Resident #89 refusing a shower.

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 10/28/2014

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 312	Continued From page 123	F 312		

During an initial interview on 10/12/14 at 3:51 PM Resident #89 stated she had not had many showers since her admission to the facility and was supposed to get 2 a week.

An interview with NA #3 on 10/16/14 at 8:36 AM revealed shower assignments were in a notebook at the desk and most residents had 2 to 3 showers a week. NA #3 stated some days there was a shower team but otherwise the NAs completed showers for their assigned residents.

A subsequent interview with Resident #89 on 10/16/14 at 8:30 AM revealed she had her third shower since admission on 10/15/14. Resident #89 stated her bottom felt a little sore yesterday due to the lack of showers.

An interview was conducted with the Director of Nursing (DON) 10/16/14 at 10:35 AM. During the interview Resident #89's skin assessment sheets dated 09/27/14 and 10/01/14 were observed and an NA had written on the sheet both days the resident had refused her shower. The DON stated the NA's were expected to document on the skin assessment sheet any time a resident refused a shower and also tell the nurse so she could document this in the nurse's notes. The interview further revealed when a resident refused a shower there was no policy for either offering again the same day or on another day. A subsequent interview with the DON on 10/16/14 at 4:00 PM revealed he spoke with NA #5 after he determined she had cared for Resident #89 on 10/08/14 and 10/11/14. The DON indicated NA #5 told him Resident #89 had refused her showers on 10/08/14 and 10/11/14 but did not know she was supposed to write the refusal on

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 10/28/2014

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 312	Continued From page 124 the skin assessment or notify the nurse. A follow up interview with Resident #89 on 10/17/14 at 11:05 AM revealed she did refuse her shower on 09/27/14 because she was too tired. Resident #89 stated the first time she was offered and received a Wednesday shower since her admission was on 10/15/14. Resident #89 further stated she may have told the NAs she could not take her shower at the time they offered but she did not recall ever refusing a shower when offered. During an interview on 10/20/14 at 12:05 PM NA #5 stated she could not recall the exact dates but did remember Resident #89 requested to get her shower later in the day a couple of times. NA #5 indicated she was a recent hire and she did not know she needed to inform the nurse or document on the skin assessment sheet when a resident did not want a shower. The interview further revealed NA #5 did not offer Resident #89 a shower later or pass this information on to the next shift. An interview with Nurse #4 on 10/20/14 at 2:44 PM revealed the NAs were expected to report to the nurse any time a resident refuses a shower so the nurse can document in the medical record after they speak to the resident and ask why they declined their shower. Nurse #4 stated the NAs were also supposed to write shower refusal on the skin assessment sheet.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		12/5/14

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 10/28/2014

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 314	Continued From page 125 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff, physician and resident interviews the facility failed to assess a resident with skin excoriation that progressed to a stage 2 pressure sore and failed to conduct weekly skin assessments for 2 of 3 residents reviewed for pressure sores. (Resident #58 and #91). The findings included: 1. Resident #58 was admitted to the facility on 09/03/14 with diagnoses which included chronic respiratory failure, heart disease, chronic pain, vitamin deficiency, esophageal reflux and anxiety. A review of the admission Minimum Data Set (MDS) dated 09/12/14 indicated Resident #58 had no short term or long term memory problems and was cognitively intact in daily decision making. The MDS also indicated Resident #58 required limited assistance with activities of daily living and Section M of the MDS titled Skin Conditions indicated Resident #58 was at risk for developing pressure ulcers but had no pressure ulcers at stage 1 or higher. A review of a care plan dated 09/17/14 indicated a problem statement for the potential for skin	F 314	1. Resident #58 no longer resides in the facility. Resident #91 had a skin assessment completed on 11/1/2014 by the licensed nurse. 2. All residents have the potential to be affected by this citation. A skin assessment and measuring of wounds was completed by the Registered Nurse on current residents 11/24/2014-12/04/2014. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced certified nurse assistants on reporting of any skin issues 11/10/2014-12/04/2014.. The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses on performing skin assessments, reporting of new wounds via 24 hour report after physician and family notified, receiving orders from the physician for wound/skin treatments and measuring of wounds weekly by the treatment nurse. . The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of 10 residents	

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 10/28/2014

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 314	Continued From page 126 integrity impairment related to decreased mobility. The goals indicated skin will remain intact as evidenced by no skin breakdown and the approaches were listed in part for pressure reducing device to bed or chair as ordered; encourage frequent position changes and assist as needed; weekly skin sweeps per hall nurse; skin assessment for risk of skin breakdown per facility schedule; provide treatments as ordered; encourage good nutrition and hydration and monitor labs as ordered and notify physician of results. A review of a physician's order dated 09/17/14 indicated to cleanse open area to buttock with wound cleanser. Apply polymem dressing (used to cleanse, fill absorb and moisten the wound) and cover with tegaderm (a transparent dressing to cover and protect wounds). Change dressing every 3 days and as needed. Discontinue dressing when healed. A review of the most recent Braden Scale skin assessment for predicting pressure sore risk dated 09/24/14 revealed a total score of 17 which indicated Resident #58 was at risk for development of pressure ulcers. A review of a weekly skin integrity review dated 09/24/14 indicated in a section labeled Current Skin Condition: Redness, Open Area and a handwritten note indicated treatment followed. However, there was no description of the open area. A review of a treatment record dated 10/13/14 indicated a dressing change was done and was due to be changed again on 10/16/14. There was no description of the open area.	F 314	weekly skin assessments and wound measurements 5 times a week for eight weeks, 3 times a week for eight weeks, 2 times a week for four weeks and 1 time a week for four weeks and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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 314	Continued From page 127	F 314		

A review of weekly wound measurements revealed there were no wound measurements or descriptions for the open area on Resident #58's buttocks.

During an interview on 10/15/14 at 9:50 AM Resident #58 stated her skin was very fragile and tore very easily. She explained she had a sore on her bottom that was there when she came to the facility and it was painful especially when she sat on it and caused pressure to the area. She stated it had a dressing on it and she thought the dressing was changed about once a week.

During an interview on 10/15/14 at 10:11 AM with Nurse #1 who was also the facility wound care nurse explained the wound on Resident #58's bottom was excoriation (where skin had been rubbed off) and she had not measured the area because she had not classified it as a pressure ulcer. She stated she did not change the dressing but the nurse on the hall did the dressing change and she was not sure when the dressing was due to be changed.

During an observation of wound care on 10/16/14 at 10:03 AM Nurse #13 removed Resident #58's pants and cleaned an open area on the resident's buttocks with wound cleanser. The open area was oozing a small amount of blood around the edges and Nurse #13 applied a foam dressing inside the open area and secured the dressing to the resident's skin with a transparent dressing.

During an interview on 10/16/14 at 11:20 AM with Nurse #13 she stated the dressing had come off when Resident #58 used the toilet and that was the reason there was no dressing on the wound

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 10/28/2014

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 314	Continued From page 128	F 314		

when she provided wound care. She explained the wound looked clean and she thought it was a wound that had been caused by pressure. She further explained Resident #58 was very thin with fragile skin and had bony prominence's that made her prone to skin breakdown. She stated the wound looked like a pressure ulcer to her but she not been trained to assess the stages of wounds.

During an interview on 10/20/14 at 2:50 PM with Nurse #4 she stated she had changed Resident #58's dressing on her buttocks last Friday on 10/17/14 because the dressing had come off. She described the wound as circular and approximately 4 centimeters long by approximately 1 centimeter wide and the wound was clean. She stated the wound nurse measured pressure ulcers but did not do any measurements of skin tears or excoriation and Resident #58's wound was still classified as excoriation.

During an observation of wound care on 10/21/14 at 8:37 AM Nurse #4 showed the Director of Nursing the open area on Resident #58's buttocks and provided wound care.

During an interview on 10/21/14 at 8:43 AM the Director of Nursing stated the wound on Resident #58's buttocks was a stage 2 pressure ulcer and was not excoriation of the skin. He also verified documentation on weekly skin integrity review sheets was unclear and there should have been documentation as to exactly where the wound was located and the stage of the wound.

During an interview on 10/21/14 at 9:15 AM the physician who was also the facility Medical Director stated he was not aware of Resident

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 10/28/2014

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 314	Continued From page 129	F 314		

#58's wound on her buttocks until staff told him about it after he had arrived at the facility that morning. He explained the facility had a wound nurse who did all weekly wound measurements. He stated he assessed wounds when residents were admitted to the facility or when the wound nurse had questions and he expected to be called if a wound worsened or did not respond to treatment.

During a follow up interview on 10/22/14 at 8:28 AM the Director of Nursing explained the wound nurse assessed pressure ulcers and did wound measurements on Monday of each week. He explained the nurse who was assigned to the resident did the weekly skin assessments and if they saw something it was his expectation for them to report it to the wound nurse and she should report it at the weekly wound meeting. He further explained he expected for Nurse Aides (NAs) to report concerns about resident's skin when they gave residents showers and baths and the nurses should report any new skin concerns to the physician for evaluation and treatment.
2. Resident #91 was admitted to the facility on 07/07/14 with diagnoses of quadriplegia, coronary artery disease and hypertension. The admission Minimum Data Set (MDS) dated 07/14/14 indicated Resident #91 was cognitively intact. The MDS further indicated Resident #91 was dependent for bed mobility and was admitted to the facility with 3 stage 2 pressure ulcers.
Review of Resident #91's care plan dated 07/23/14 revealed he had potential for skin integrity impairment related to decreased mobility and was admitted with pressure areas to the left coccyx and left iliac crest. Interventions included pressure reducing device to the bed and chair, frequent position changes and assist as needed,

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 10/28/2014

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 314	Continued From page 130	F 314		

weekly skin sweeps per hall nurse, provide treatment as ordered, monitor labs as ordered and notify doctor of results, provide supplements as ordered.
Review of the Weekly Wound Assessment Sheets dated 07/08/14 thru 08/25/14 revealed Resident #91 was admitted to the facility with stage 2 pressure ulcer's to his left coccyx and left iliac crest with a healed date of 07/22/14 for the left coccyx and 07/22/14 to the left iliac crest. The wound assessment sheet indicated Resident #91 developed a stage 2 pressure ulcer to his left sacrum on 08/18/14 which was healed on 08/25/14.
Review of the Weekly Wound Assessment Sheets dated 09/15/14 thru 10/19/14 revealed Resident #91's pressure ulcers were not assessed on 10/06/14 and had increased in size from 1.1 centimeters (cm) by 0.3 cm on 09/29/14 to 2 cm by 2.2 cm on 10/13/14.
An interview was conducted on 10/14/14 at 10:22 AM with Nurse #1. She stated she was responsible for measuring wounds in the facility and all measurements were done on Mondays. She stated hall nurses were responsible for dressing changes and treatments. Nurse #1 further stated if she was not there on a Monday the hall nurse was responsible for doing measurements.
An interview was conducted on 10/21/14 at 9:06 AM with the Medical Director (MD). He stated the facility had a Wound Nurse that did all weekly wound measurements. He stated he assessed the wounds on admission to the facility or when the Wound Nurse had questions.
An interview was conducted with the Director of Nursing on 10/22/14 at 8:30 AM. He stated it was his expectation for all weekly skin checks and dressing changes to be completed as ordered.

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 10/28/2014

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 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to use soap and water or peri wash during incontinence care, failed to provide catheter care during incontinence care, failed to ensure a resident was clean after toileting and failed to wipe from front to back during incontinence care for 4 of 4 residents observed during incontinence care. (Residents # 61, #100, and #60). The findings included: 1. Resident #61 was re-admitted to the facility on 09/14/14 with diagnoses which included debility, osteoarthritis, high blood pressure, anxiety, depression and contractures of upper and lower extremities. A review of the most recent annual Minimum Data Set (MDS) dated 09/21/14 indicated Resident #61 had no long term or short term memory problems and was cognitively intact for daily decision making. The MDS also indicated Resident #61 was totally dependent on staff for activities of daily living, had an indwelling	F 315	1. Resident # 61 was not injured related to this citation. Resident # 100 was not injured related to this citation. Resident #60 was not injured related to this citation. NA #4 was in serviced by the Director of Clinical Services on providing proper peri care and catheter care on 11/19/2014. NA #5 was in serviced by the Director of Clinical Services on providing proper peri care and catheter care on11/19/2014. NA #8 was in serviced by the Director of Clinical Services on providing proper peri care and catheter care on 11/19/2014. 2. All residents have the potential to be affected by this citation. Observations of peri care and catheter care were completed 11/19/2014-11/28/2014 by the Director of Clinical Services and/or Nursing Supervisor.	12/5/14

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 10/28/2014

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 315	Continued From page 132 urinary catheter and was incontinent of bowel. The MDS also revealed Resident #61 had a urinary tract infection in the last 30 days. A review of a care plan updated on 09/30/14 indicated Resident #61 had an indwelling urinary catheter related to urinary retention and had the potential for urinary tract infections. The goal specified Resident #61 would remain free of signs and symptoms of urinary tract infection. During an observation on 10/15/14 at 9:28 AM Nurse Aide (NA) #4 and NA #5 provided incontinence care to Resident #61. The sheet covering Resident #61 was removed and the resident was lying on a protective pad with an indwelling catheter in place. Resident #61 was turned to his right side and had a moderate amount of soft brown stool. NA #4 wiped the resident's buttocks from front to back with wash cloths that appeared to be wet then turned him on his left side and placed a wedge to his back and covered him with the sheet. NA #4 and #5 removed their gloves and washed their hands and took the soiled linens out of the room. During an interview on 10/15/14 at 9:45 AM with NA #4 she verified water was the only substance on the washcloths she used to remove the stool from Resident #61's bottom. She explained she thought peri wash burned his skin but she had not asked if she should use soap or any other products to clean his skin. NA #4 stated she did not wash Resident #61's front perineal area or clean around his urinary catheter because she had already cleaned around his catheter earlier that morning. She explained she knew she should have cleaned his front perineal area and around the catheter but she was very nervous	F 315	New Hire Certified Nurse Assistants will have training for peri care and catheter care using soap and water and/or peri wash during the orientation process. 3. The Director of Clinical Services in serviced certified nurse assistants on peri care and catheter care using soap and water and/or peri wash 11/10/2014-12/04/2014. The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement monitoring of 2 certified Nurse Assistant providing peri care each shift 5 times a week for 1 month, 3 times a week for 1e month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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

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F 315	Continued From page 133	F 315		

and she was not sure if she could clean his bottom and then go to the front to clean around his penis and catheter.

During an interview on 10/21/14 at 12:15 PM the Director of Nursing stated it was his expectation for staff to follow the facility policy and clean a resident during incontinence care with peri wash or soap and water. He further stated he expected staff to clean around urinary catheters during incontinence care.

2. Resident #100 was admitted to the facility on 04/17/14 with diagnoses which included Parkinson's disease and dementia. A review of the most recent quarterly Minimum Data Set (MDS) dated 08/16/14 indicated Resident #100 had short term and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #100 required extensive assistance by staff for toileting and hygiene, and was incontinent of bladder and bowel. The MDS also revealed Resident #100 had a urinary tract infection in the last 30 days.

A review of a care plan dated 04/30/14 indicated Resident #100 had the potential for urinary tract infections and the goal was to remain free of urinary tract infections.

A review of a laboratory report for a urinalysis and culture and sensitivity dated 10/10/14 indicated Escherichia coli (a bacteria of the intestines).

A review of a physician's order dated 10/14/14 indicated Macrobid 100 milligrams by mouth twice daily for 7 days for urinary tract infection.

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 315	Continued From page 134	F 315		

During an observation on 10/15/14 at 2:39 PM Nurse Aide (NA) #5 assisted Resident #100 in her bathroom to a standing position from her wheelchair, pulled the resident's pants down and pivoted her to sit on a raised toilet seat. Resident # 100's brief was wet with dark yellowish/brown colored liquid. Resident #100 urinated in the toilet then took a piece of toilet tissue and reached behind her back and wiped herself from back to front with dry toilet tissue. NA #5 placed a clean brief between Resident 100's legs, assisted her to stand and pulled the brief up without looking to see if the resident was clean and dry and did not use peri wipes or soap and water to clean the resident's bottom. NA #5 assisted Resident #100 to transfer to her wheelchair and transported her out of the bathroom.

During an interview on 10/16/14 at 7:25 AM with NA #5 she explained when she toileted Resident #100 yesterday her brief was wet and her urine looked so dark because she had a urinary tract infection. She stated sometimes she cleaned Resident #100's bottom but since the resident liked to wipe herself, she just let her. She further stated she did not look to see if Resident #100 had gotten herself clean after toileting and she did not notice which direction Resident #100 wiped but she probably should have since she had a urinary tract infection.

During an interview on 10/21/14 at 12:15 PM the Director of Nursing stated it was his expectation for staff to make sure a resident was clean after they were toileted and staff should make sure residents were cleaned from front to back especially if they had a history of urinary tract infections.

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 135	F 315		

3. Resident # 60 was readmitted to the facility 08/15/14 with diagnoses which included urinary tract infection, debility, and urinary retention. A quarterly Minimum Data Set (MDS) dated 09/28/14 indicated the resident's cognition was intact. The MDS specified Resident #60 required extensive staff assistance for bed mobility, dressing, and toilet use and was dependent on staff assistance for bathing and transfers. The MDS further specified the resident had an indwelling urinary catheter.

A care plan dated 08/27/14 described Resident #60 had the potential for urinary tract infections related to an indwelling urinary catheter. The care plan goal specified the resident would remain free of signs and symptoms of a urinary tract infection. Interventions included provide catheter care every shift.

An observation was conducted of Nurse Aide (NA) #8 providing catheter care on 10/17/14 at 9:55 AM. NA #8 utilized a wash cloth that appeared wet to wash the perineal area. He changed wash cloths between perineal care and cleaning the catheter. During the observation, NA #8 was asked what was on the wash cloth. He replied water.

An interview was conducted with NA #8 on 10/22/14 at 9:17 AM. NA #8 acknowledged water was the only substance on the wash cloths he utilized for Resident #60's catheter care on 10/17/14. NA #8 stated he usually used a peri wash product for catheter care and should have this time. He stated the peri wash product should be used with peri care and catheter care.

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 10/28/2014

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

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F 315	Continued From page 136 An interview with the Administrator on 10/17/14 at 10:15 AM revealed use of soap and water or a peri wash was expected to be used with all indwelling urinary catheter care.	F 315		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff and resident interviews, the facility failed to provide range of motion exercises and apply splints to prevent/decrease contractures for 3 of 4 residents reviewed for contractures. (Residents #24, #61, #91,) The findings included: 1. Resident #24 was readmitted to the facility 06/21/13 with diagnoses which included history of stroke with left sided paralysis and dysphagia. A Minimum Data Set (MDS) dated 08/15/14 indicated the resident's cognition was intact. The MDS specified Resident #24 required extensive staff assistance bed mobility, transfers, toilet use, and personal hygiene, and was totally dependent on staff for bathing. The MDS further specified the resident had range of motion impairment in	F 318	1. Resident #24 was assessed by the physician on 11/20/2014 with new orders noted. Resident #61 was assessed by the physician on 11/18/2014 with new orders noted. Resident #91 was assessed by the physician on 11/18/2014 with no new orders noted. 2. Residents that have splints have a potential to be affected by this citation. An audit of current residents with splints was completed on 11/21/2014-12/04/2014 by the Director of Clinical Services and/or Nursing Supervisor. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced	12/5/14

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 10/28/2014

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CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

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F 318	Continued From page 137 upper and lower extremities on one side. A review was conducted of an undated Nurse Tech Information Kardex. Under the heading Adaptive Devices was written "Hand splint L (L was circled meaning left) 4-6 hrs (hours) day." A review was conducted of an Occupational Therapy Treatment Encounter Note dated 09/05/14. The document specified education was provided to the future restorative aide regarding how to stretch the resident's left upper extremity and how to apply a splint to the left hand. Further review revealed the resident was being discharged from therapy and referred to restorative to prevent contractures in the resident's left hand and arm. The document further specified teaching range of motion techniques and application of splint to the restorative aide was completed with return demonstrations. The document was signed by the Certified Occupational Therapy Aide (COTA). A review of a document dated 09/30/14 and entitled Therapy to Restorative Nursing Recommendations was conducted. The document provided instructions for range of motion and splint assist to upper extremity 4 to 6 hours. The form was signed by a former occupational therapist. A review of a Restorative Tracking Form dated October 2014 was reviewed. The form contained range of motion and splinting was to be provided to Resident #24. The dates of October 1 through 4 were initialed and indicated completion of the task. No other dates for the month of October were initialed on the form. No tracking form was provided for September 2014.	F 318	licensed nurses and certified nurse assistants on applying splints and range of motion 11/20/2014-12/4/2014. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of the application of splints with range of motion 5 times a week for 1 month, 3 times a week for 1e month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

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F 318	Continued From page 138	F 318		

An observation on 10/14/14 at 9:59 AM revealed Resident #24 was sitting in her wheel chair. Her left arm was observed lying flaccid in her lap. There was no splint on her left arm.

An additional observation and interview on 10/17/14 at 8:35 AM revealed Resident #24 was sitting in her wheel chair with her left hanging by her left side. Resident #24 picked up her left arm with her right hand and placed it on the wheel chair arm. Resident #24 stated before she was admitted to this facility, her left arm was contracted up to her chest. She stated she saw a specialist in a neighboring state that provided treatments that allowed her left arm to relax and relieved the contracture. The fingers on Resident #24's left hand were observed curled into the palm of the hand. Resident #24 straightened the curled fingers with her right hand. The resident stated she had a splint that was supposed to be applied to her left arm for several hours per day. Resident #24 stated this week, she had not had the splint since Monday (10/13/14).

An interview with Nurse Aides (NA) #8 and #10 was conducted 10/17/14 at 9:53 AM. The NAs confirmed they were usually assigned to Resident #24's hall. Both the NAs stated they did not apply splints or do range of motion to Resident #24's left hand. NA #8 stated the restorative aide does those things.

An interview was conducted with the COTA on 10/17/14 at 10:37 AM. The COTA stated she worked with Resident #24 in therapy to prevent contractures of her left arm and hand. The COTA stated after therapy, she was turned over to the facility's restorative aide that she trained to do

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 10/28/2014

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

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F 318	Continued From page 139	F 318		

stretching of the left arm joints and fingers. The COTA added Resident #24 was in danger of the left hand getting tighter which would prevent cleaning of the hand and lead to skin breakdown. The COTA stated the splint should be worn 4 to 5 hours per day. She added if the restorative aide was not available, the NAs caring for the resident should apply the splint and provide range of motion to the arm and fingers.

An interview was conducted with the Assistant Director of Nursing (ADON) on 10/20/14 at 12:10 PM. The ADON stated splint application and range of motion was not written as a physician's order. After a resident was assessed by therapy, the therapist gave nursing staff recommendations and instructions for splint application and range of motion.

An interview was conducted with the Director of Nursing (DON) at 10/20/14 at 10:32 AM. He stated if the therapist recommended splint use, the nurses should be responsible for seeing splints were correctly applied as recommended.

A continued interview with the DON on 10/21/14 at 11:30 AM revealed he and the ADON were in the process of revising Restorative Nursing Program. He stated the nurse aide they had been training for several weeks to be the Restorative Aide submitted her resignation 4 days ago. Therefore there was no restorative aide in the facility at present.

2. Resident #61 was originally admitted to the facility on 09/28/12. His diagnoses included quadriplegia, chronic pain, anxiety, and depression.

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 10/28/2014

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 318	Continued From page 140	F 318		

The quarterly Minimum Data Set (MDS), dated 04/29/14, coded him with no cognitive impairments, requiring total assistance with all activities of daily living skills (ADLs) and receiving no restorative services or therapies.

Review of the medical record revealed Occupational Therapy (OT) was provided to Resident #61 from 07/08/14 through 08/04/14. The discharge summary stated that the goals for Resident #61 for therapy included:
*to tolerate gentle passive stretching to both upper extremities (BUE) with minimum discomfort; and
*to tolerate wearing splints for 4-6 hours with no discomfort.
The discharge summary indicated that when discharged on 08/04/14, Resident #61 met the goals as he improved from moderate discomfort to minimum discomfort with gentle passive stretching to BUE and he tolerated wearing splints from not at all to 4-6 hours per day without discomfort.

Physician telephone orders dated 08/04/14 included the discontinuation of OT treatment and referral to restorative for passive range of motion and BUE splinting. This was signed by the physician on 08/05/14.

The OT discharge recommendations signed by the occupational therapist on 08/05/14 included a restorative program for passive range of motion and applying splints. Equipment included splints for BUE.

The quarterly MDS, dated 08/16/14, coded him with no cognitive impairments and receiving no

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 10/28/2014

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 318	Continued From page 141	F 318		

restorative services or therapies. This MDS coded him with functional limitation in range of motion with impairment on both sides for his upper and lower extremities.

The annual MDS dated 09/21/14 coded him with no cognitive impairments and receiving no restorative services or therapies.

The Certified Occupational Therapy Aide (COTA) provided the surveyor with a form named "Therapy to Restorative Nursing Recommendations." This form dated 09/30/14 recommended passive range of motion to bilateral upper and lower extremities with 10 repetitions each and BUE splints to be worn 4-6 hours.

Review of the medical record revealed no documentation of range of motion or splints being applied from 08/05/14 until 10/01/14. The Restorative Tracking Form noted passive range of motion and splinting was provided 10/01/14 through 10/04/14. The October 2014 computerized monthly physician order sheet had the hand written addition to apply arm splints to bilateral arms every day for 4-6 hours then remove and noted the application time to be 1:00 PM. Review of the Medication Administration Record (MAR) revealed initials indicating splints were applied except there were no initials on 10/01/14, 10/04/14, 10/05/14 and 10/16/14. These spots were blank and there was no notation on the back indicating why the blanks or any refusals or problems on the days the initials were in place.

On 10/13/14 at 8:17 AM Resident #61 was observed in bed with both hands curled in

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 10/28/2014

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 318	Continued From page 142	F 318		

contractures. There were soft "carrots" (a carrot shaped device to keep in fisted hands) on the overbed table. At 9:24 AM, Resident #61 stated he felt his hands were "locking up" and less usable. He stated restorative stopped putting his hand splints in place, but was not specific to the time frame it has been since splints have been applied. Above his bed was a sign named "Splinting Program" which was undated. The sign included 4 steps:
1. 1st perform passive range of motion to both upper extremities holding each repetition for 10-15 seconds.
2. Next apply splint to hand.
3. Resident should wear splint for 4-6 hours.
4. Splints should be worn every day.

Resident #61 was observed without splints in place on 10/13/14 at 4:52 PM; 10/14/14 at 7:40 AM, 7:57 AM, 9:09 AM, 10:27 AM, 11:37 AM, 12:33 PM, 12:43 PM, 2:52 PM, and 4:48 PM; On 10/15/14 at 8:48 AM, 10:40 AM, 11:34 AM, 1:16 PM, 1:50 PM, and at 2:57 PM.

Interview with Nurse Aide #4 on 10/15/14 at 8:48 AM revealed that there was a restorative aide who was responsible for providing range of motion and applying Resident #61's splints.

Interview with the Director of Nursing (DON) and Assistant Director of Nurse (ADON) on 10/15/14 at 4:21 PM revealed they had just started the restorative program and have not even billed for it yet. A physical therapist has been training an aide to do restorative services, however she just resigned. DON stated that if there was restorative services or splints recommended then the nurses on the hall were responsible to provide the services. He further stated that the MAR

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 318	Continued From page 143	F 318		

should indicate that restorative services were provided.

Interview on 10/15/14 at 4:29 PM with the second shift Nurse Aide (NA) #6 who routinely worked with Resident #61 and started her shift at 3:00 PM revealed it had been weeks since she has had to remove his splints as they have not been in place.

Observations revealed no splints in place on 10/16/14 at 6:40 AM, 7:41 AM, and 8:30 AM. On 10/16/14 at 8:30 AM Resident #61 stated he wanted to wear his splints. His splints remained off during observations on 10/16/14 at 10:09 AM, 12:52 PM, and at 3:20 PM.

On 10/17/14 at 11:17 AM, Resident #61 was observed without splints in place. He stated at this time, staff did not put them on yesterday.

COTA stated during interview on 10/17/14 at 11:29 AM that she had seen him for splinting and range of motion. She stated he was currently discharged from OT and she had put up the functional maintenance program (sign above his bed) in his room. She further stated that since there was no restorative program, staff were expected to provide the recommended restorative services and apply the splints.

Interview with Nurse #4 on 10/17/14 at 12:08 PM revealed that restorative was supposed to put Resident #61's splints in place. She stated she had put them on once before. She stated he sometimes wanted the splints on and sometimes he refused. She stated that sometimes he only wore the splints 10-15 minutes. She stated that when she signed off the MAR that the splints

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 10/28/2014

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 318	Continued From page 144 were on she did see them in place. She stated that if he refused the splints then the initials should be circled on the MAR. She could not recall any refusals by him to wear the splints. In terms of responsibility to report that a resident refused splints or did not wear them as scheduled, she stated the restorative aide was responsible for reporting that. Follow up interview with COTA on 10/17/14 at 1:02 PM revealed Resident #61 was discharged from therapy with splints in August 2014. The plan was developed and posted above his bed. She stated at the time of discharge, there was no restorative program and she was unsure who was responsible for the splints. 3. Resident #91 was admitted to the facility on 07/07/14 with diagnoses of quadriplegia, coronary artery disease and hypertension. The admission Minimum Data Set (MDS) dated 07/14/14 indicated Resident #91 was cognitively intact. The MDS further indicated Resident #91 had range of motion (ROM) impairment for upper and lower extremities with resident and staff believing he was capable of increased independence in ROM. Review of the Occupational Therapy note dated 09/12/14 revealed Resident #91 was to have passive stretching to his bilateral upper extremities to increase ROM and muscle	F 318		

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 10/28/2014

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 318	Continued From page 145	F 318		

elasticity for ease of care and to prevent/reduce contractures and skin breakdown. Active range of motion (AROM) exercises to bilateral upper extremities to increase strength, flexibility and functional activity tolerance for increased ability for activities of daily living and dexterity for wheelchair management. The Restorative Aide was instructed in ROM exercises and splinting wear and care, and performed a return demonstration.
Review of Therapy to Restorative Nursing Recommendations dated 09/30/14 revealed Resident #91 was to receive ROM to his bilateral upper and lower extremities for 10 repetitions of each extremity and splints to the right hand and left elbow 4 to 6 hours per day.
Review of Resident #91's care plan revealed no care plan was initiated for ROM to bilateral upper and lower extremities and splints to right hand and left elbow 4 to 6 hours per day.
Review of Restorative Tracking Form dated 10/15/14 for Resident #91 revealed he received active range of motion and splinting by Nurse Aide (NA) #2 on the 7:00 AM to 3:00 PM shift for a total of 45 minutes.
Observations made of Resident #91 on 10/13/14 at 4:48 PM, 10/14/14 at 3:05 PM, 10/15/14 at 8:45 AM, 10/15/14 at 9:43 AM, 10/15/14 at 11:20 AM, 10/16/14 at 8:39 AM, 10/16/14 at 11:00 AM, 10/17/14 at 9:12 AM and 10/20/14 at 11:45 AM revealed no splints to his right hand or left elbow.
An interview was conducted on 10/15/14 at 9:24 AM with the Occupational Therapy Aide. She stated Resident #91 was discharged from Occupational Therapy to Restorative Nursing Therapy on 09/12/14. She reported Resident #91 was wearing splints on his right hand and left elbow and the Restorative Aide was trained by the Occupational Therapist how to put on splints 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 10/28/2014

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

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F 318	Continued From page 146 perform AROM with him. An interview was conducted on 10/15/14 at 9:34 AM with Nurse #1. She reported the Restorative Aide had not worked the past 2 days and there was not a backup Restorative Aide. An interview was conducted on 10/15/14 at 2:30 PM with Resident #91. He stated after he was discharged from therapy the restorative aide applied his splints and did exercises with him daily. He reported he went out to the hospital on 10/07/14 and returned to the facility on 10/10/14 and had not had anyone put his splints on or do exercises with him since he returned. An interview was conducted on 10/17/14 at 9:47 AM with the MDS Coordinator. She reported she did not do a ROM and splint care plan until she was notified by the Restorative Aide that the resident had been referred to Restorative Nursing. She stated she had not been notified that Resident #91 had been referred to Restorative Nursing. An interview was conducted on 10/17/14 at 12:38 PM with NA #2. She stated therapy had taught her how to put Resident #91's splints on last month. She stated she had not put Resident #91's splints on since his return from the hospital on 10/10/14. She stated the restorative nurse was to put splints on and do AROM with Resident #91. An interview was conducted on 10/21/14 at 11:30 AM with the Director of Nursing. He stated the Restorative Nursing Program was in the process of being revised by himself and the Assistant Director of Nursing. He reported the Restorative Aide had turned in her resignation 2 days ago and there was no Restorative Aide in the facility. He stated Resident #91 should have had splints applied to right hand and left elbow and AROM daily.	F 318		

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 10/28/2014

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 147	F 323		
F 323 SS=E	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 observations, record reviews, staff interviews and family interview, the facility failed to investigate the circumstances surrounding falls and implement planned interventions to prevent reoccurring falls for 2 of 8 sampled residents (Residents #94 and #100) who had histories of falls; and failed to investigate and identify how prescription discontinued and currently prescribed inhalers were repeatedly found at 1 of 8 resident's bedside (Resident #58) who were sampled for medication review. The findings included: 1. Resident #100 was admitted to the facility on 04/17/14. Her diagnoses included Parkinson's disease, history of traumatic brain injury, dementia, gastroesophageal reflux, hypothyroidism and hyperlipidemia. Per the Situation Background Assessment and Request (SBAR) communication form in the medical record dated 04/18/14 Resident #100 fell on this date. Per the Fall Investigation form, the fall occurred at 5:30 AM after she was sleeping	F 323	1. Resident #100 was seen by the physician on 11/18/2014 with new orders received. Resident #100 care plan was reviewed and updated 11/20/2014-11/26/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Minimum Data Set Nurse, Social Services, Activities). Resident Resident #58 no longer resides at the facility. Resident # 94 was seen by the physician on 11/18/2014 with new orders noted. Resident #94 care plan was reviewed and updated 11/20/2014-11/26/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Minimum Data Set Nurse, Social Services, Activities). 2 All residents have the potential to be affected by this citation. Observations for medications at the bedside was completed by the	12/5/14

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 10/28/2014

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 148	F 323		

and got out of bed to go to the bathroom. This form noted that Resident #100 did not appear to understand how to use the call bell. This form also noted that her family stated she had frequent falls and forgot she could not walk. The supervisor report on the back of this form, dated 04/21/14 noted that the care plan was updated to reflect the bed and chair alarm.

An admission care plan originally dated 04/17/14 was updated to reflect a fall on 04/18/14 and the addition of a bed and chair alarm was to be used. The falls committee meeting notes dated 04/24/14 noted the plan for a bed and chair alarm. Interview with the Director of Nursing (DON) on 10/16/14 at 10:27 AM revealed the interdisciplinary team held a morning meeting daily which included discussion of falls that occurred. The DON confirmed that a chair and bed alarm was to be implemented following this fall and should have been care planned.

The admission Minimum Data Set (MDS) dated 04/24/14 coded her with usually being understood and usually understands, having some inattention and disorganized thinking, having moderately impaired cognition (scoring a 10 out of 15 on the brief interview for mental status), requiring total assistance with bathing, extensive assistance with bed mobility, transfers, toileting and limited assistance with ambulation in room, hygiene, and dressing. She was coded as needing assistance of staff to balance and being frequently incontinent of urine and receiving antipsychotic medications in the previous 7 days. She was inaccurately coded as having had no fall history.

The Care Area Assessment dated 04/30/14 relating to falls included her age and diagnoses.

Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) 11/17/2014-11/19/2014.
Current residents care plans and kardex were reviewed and updated if needed 11/24/2014-12/4/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Minimum Data Set Nurse, Activities).
An audit of the last 30 days of falls and/or investigations was completed by the director of nursing and/or nursing supervisor 11/24/2014-12/04/2014.

3. The Director of Nursing and/or Nursing Supervisor in serviced licensed nurses on policy for assessing a resident for self administration of medications, notification to Director of Clinical Services if medications are found and receiving order from physician for resident to self administer11/10/2014-12/04/2014.

The Regional Case Mix Coordinator in serviced the Minimum Data Assessment Nurse, Director of Social Services, Activities Director, Dietary Director and the Director of Nursing and/or Nursing Supervisor on completion of care plans or updating care plans with measureable goals with individualized interventions.

The Regional Director of Clinical Services in serviced the Interdisciplinary team, (Director of Clinical Services, Assistant Director of Clinical Services, Social Services Director, Activities, Minimum Data Set Nurse) on completion

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 10/28/2014

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 149 She was noted to have the potential for falls related to decreased mobility, use of psychotropic medications and incontinence. On 04/30/14 a comprehensive care plan was developed for the problem for potential for falls with a goal to remain free from falls through nursing interventions and prevention as evidence by no fall through 07/31/14. Interventions included: *keep adjustable bed in lowest position; *assist with transfers as needed; *keep call light and personal items in reach; *encourage resident to call for assistance; *encourage nonskid footwear; *keep clutter free environment; *monitor adverse side effects of medications; *therapy as indicated; and *provide appropriate safety devices as needed. This care plan did not include the use of a bed and/or chair alarm. Per the SBAR communication form in the medical record, on 06/21/14 Resident #100 was found on the floor on her back. No time was noted on this form but the responsible party was notified at 7 PM. There were no details of the circumstances of the fall or if an alarm was in place or sounded. The Falls committee meeting notes dated 06/23/14 revealed a physical therapy screen and education was implemented. Record review revealed the resident was already under the care of physical therapy from 06/02/14 through 07/30/14. A quarterly MDS was dated 08/16/14 which coded her as moderately cognitively impaired, having verbal behaviors towards others, requiring extensive assistance for bed mobility, transfers	F 323	of an investigation using witness statements, fall investigation paperwork and updating care plans and putting interventions in place to prevent reoccurrence 11/24/2014-11/26/2014. The Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) will perform Quality Improvement monitoring of 10 resident rooms for medications at the bedside 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks, 1 time a week for 4 weeks and/or substantial compliance obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of investigations and fall care plans interventions have been implemented 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks and/or until substantial compliance is obtained. 4 The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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 150	F 323		

and only walking in the room or corridor less than twice in look back period. She was coded as having 2 or more falls since the last assessment.

Per the SBAR communication form, Resident #100 was found sitting on the floor beside her bed on 08/16/14 at 11:00 PM. The form stated the resident stated she was getting up to turn off the television. The form did not address if an alarm was in place or sounded. Review of the fall investigation forms which included witness statements revealed the resident had not turned her call light on, she had been taken to the bathroom, been placed in her wheelchair, and had tried to get up from the wheelchair at least once while staff were assisting her. Per the supervisor report on this form dated 08/18/14 the plan was to educate the resident and have therapy screen her. Per record review she was under physical care services from 08/05/14 through 09/24/14. There was no information relating to if an alarm was in place or sounding. Review of fall committee minutes dated 08/18/14 revealed she fell on 08/16/14 from her chair at the sink with a plan for a therapy screen.

Another nursing note dated 08/17/14 at 5:00 PM noted the resident was found in the floor from wheelchair. This fall was not tracked on the incident and accident log and there was no investigation relating to this incident. Interview with the DON on 10/16/14 at 10:27 AM revealed the resident was to have 2 therapy screens to address a fall from the bed and a fall from the wheelchair. No additional information relating to this fall was provided.

The fall care plan was updated on 08/19/14 with dycem (a nonskid surface) added to 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 10/28/2014

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 151	F 323		

wheelchair. The care plan still did not have anything related to alarms in bed or in the wheelchair.

On 10/08/14 at 6:30 PM a nursing note noted Resident #100 had a fall to the floor from the bed. The SBAR communication form noted she had been sitting on the side of her bed eating dinner and attempted to stand and slid to the floor landing on her buttocks. She sustained a bruise to her left buttock and left mid back. The SBAR was silent to the use of any alarm device and noted the resident was educated to call for assistance to get out of bed. The intervention per the incident report was to place the bed in a low position, keep call light in reach, educate the resident and to place floor mats on the floor beside the bed. Interview with the DON on 10/16/14 at 10:27 AM revealed the care planned intervention following this fall was for a low bed. ON 10/17/14 at 1:23 PM, DON provided the fall committee minutes dated 10/09/14 indicating the plan of care was to include lowering the bed (already care planned) and providing floor mats. Per the minutes the floor mats were ordered and came in on 10/15/14.

Resident #100's SBAR form dated 10/13/14 revealed a fall at 11:45 AM when she was found sitting on her buttocks on the floor from her wheelchair. She stated she walked over to run up the television and went to sit back down and missed her seat. Interview on 10/16/14 at 10:27 AM with the DON revealed this fall had not been reviewed for interventions yet.

Resident #100 was observed in her wheelchair on 10/13/14 at 10:13 AM. There was no chair alarm in place.

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 10/28/2014

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 152	F 323		

Observations on 10/14/14 at 7:39 AM revealed Resident #100 was in the low bed asleep. There was an alarm in the bed, however, it was not flashing signifying it was on and working. There were no floor mats on the floor beside the bed. On 10/14/14 at 7:50 AM, Nurse Aide (NA) #4 served her breakfast. At this time NA #4 was asked about the bed alarm and she responded that the alarm light should be flashing and that the batteries were probably dead. Resident #100 was out of the building for several hours and was observed in her low bed on 10/14/14 at 3:49 PM. The alarm was on the bed, however, the light was not flashing indicating it was not functioning.

On 10/14/14 at 4:45 PM Resident #100 was observed in her wheelchair in the dining room. There was no alarm in place on the wheelchair. At 4:51 PM, the Assistant DON assisted the resident to stand in the dining room and observed no dycem or alarm was in the wheelchair. The surveyor interviewed NA #6, who got her out of bed and took her to the dining room on 10/14/14 at 4:54 PM. NA #6 and the surveyor looked at the alarm on Resident #100's bed and found it did not work. NA #6 confirmed the alarm did not sound when she transferred the resident from the bed to the wheelchair before taking her to the dining room. NA #6 stated the bed alarm had been in place for a few months. She further stated there was no other devices in her wheelchair she knew of to address falls. Upon follow up interview with NA #6 on 10/15/14 at 4:48 PM, NA #6 stated she was unaware of the need for any floor mats.

On 10/15/14 at 8:34 AM, Resident #100 was in the low bed asleep. There were no floor mats in place. Then at 10:25 AM the resident was

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 10/28/2014

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 153	F 323		

observed being transferred from bed to her wheelchair. There was no cushion in place in her wheelchair or dycem. There was no mat for the floor observed any where in the room. Interview on 10/15/14 at 11:18 AM with NA #4 who assisted in the transfer revealed there had not been a floor mat in place for this resident to her knowledge. She also stated that the nonskid dycem may have been attached to the cushion in her wheelchair, she was not sure, and she did not realize there was no cushion in the seat of her wheelchair.

Interview on 10/16/14 at 6:54 AM with Nurse #5 revealed that she was unaware of Resident #100 needed floor mats. She generally worked the night shift.

On 10/16/14 at 7:03 AM NA #7 who worked night shift also did not know anything about a need for floor mats.

Interview with the DON on 10/16/14 at 10:47 AM revealed that the facility did ongoing audits to check for alarms via mock surveyor programs. Review of this form however, did not have specific information related to the needs of each resident.

Resident #100's family was interviewed on 10/16/14 at 11:21 AM. Family stated they could not ever recall an alarm being used on the resident's wheelchair or any floor mats.

On 10/16/14 at 4:22 PM the DON confirmed the care plan interventions were not updated on the care plan for Resident #100.

On 10/17/14 at 9:00 AM, the central supply clerk stated there were floor mats in the storage unit

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 10/28/2014

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 154	F 323		

received over a month ago that could have been used for Resident #100.

2. Resident #58 was admitted to the facility on 09/03/14 with diagnoses including chronic respiratory failure and chronic obstructive pulmonary disease. The physician orders dated 09/03/14 revealed she was ordered a Spiriva inhaler once per day, an Albuterol sulfate nebulizer treatment 4 times a day, Xopenex (an inhaler to prevent bronchospasms) as needed and a Symbicort inhaler twice a day.

Review of telephone orders revealed on 09/04/14, the physician discontinued Xopenex.

The admission Minimum Data Set (MDS) dated 09/12/14 coded her with intact cognition, limited assistance needed for most activities of daily living skills (ADLs) and utilizing oxygen.

On 10/12/14 at 2:53 PM, Resident #58 was observed to have 2 inhalers on her bedside table. Symbicort which had a hand written date of 09/05/14 on the inhaler case and Xopenex. She stated she always kept them at bedside and used them when she needed them.

On 10/14/14 at 5:26 PM, Nurse Aide (NA) #1 stated that she had seen and reported inhalers at bedside in the past. She stated, although she was working on 10/12/14, she could not recall if the inhalers were noted at her bedside. NA #1 stated that she had been told there was a physician's order for Resident #58 to keep the inhalers at bedside.

Interview with the Resident #58's responsible

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 10/28/2014

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 155	F 323		

party and the resident on 10/14/14 at 9:15 AM revealed facility staff took the inhalers away this date. The responsible party stated the resident was supposed to have them to use but that there was no physician's order to keep them at bedside. When asked if family provided the inhalers, family stated they were aware that the inhalers were not to be brought from home. Follow up interview with the family on 10/15/14 at 9:49 AM revealed she had received no instructions to not bring inhalers from home but felt the family knew that was the expectation of the facility and that they provided the inhalers as needed.

On 10/15/14 at 9:38 AM, Nurse #4 stated that the staff have taken inhalers out of the room on previous occasions. She was not sure how they kept turning up in the resident's room. She stated she wrote a note to the physician to see if it was possible for the resident to keep inhalers at bedside but was currently unaware what had been decided about that. Nurse #4 stated she had talked to the family regarding not bringing inhalers into the facility for the resident.

Interview with NA #4 on 10/15/14 at 10:24 AM revealed that last week she turned in inhalers to Nurse #4 when she found them at bedside.

Follow up interview on 10/15/14 at 10:37 AM with Nurse #4 confirmed NA #4's account of finding inhalers at bedside which Nurse #4 locked up. At this time Nurse #4 pulled out the 2 inhalers she locked up last week. Observation revealed they were the Xopenex and Symbicort (hand written dated 09/05/14) which the surveyor had observed at bedside on 10/12/14. When told the Xopenex was discontinued, Nurse #4 disposed of it.

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 10/28/2014

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 156	F 323		

Interview with the DON and Administrator on 10/21/14 at 11:30 AM revealed they counseled the family and resident multiple times and the inhalers were removed whenever found. They stated they did not know what else they could do to rectify the situation other than checking her room for medications at bedside as they do for everyone during daily rounds.

3. Resident # 94 was admitted to the facility on 12/05/14 with diagnoses which included anxiety, depression, high blood pressure, difficulty walking, muscle spasms, history of falls and paralysis on the left side.

A review of the most recent quarterly Minimum Data Set (MDS) dated 08/08/14 indicated Resident #94 had no short term or long term memory problems and was cognitively intact for daily decision making. The MDS also indicated Resident #94 required extensive assistance by 2 staff for transfers, had range of motion impairment of his upper and lower extremities on one side and was continent of bowel and bladder.

A review of a care plan updated on 08/21/14 with a problem statement of potential for falls related to decreased mobility, use of psychotropic meds and incontinence indicated goals Resident #94 would remain free from falls through nursing interventions and prevention as evidenced by no falls. The approaches indicated in part to assist with transfers as needed, keep call light and personal items in reach at all times and encourage resident to call for assistance as needed.

A review of a Situation(S), Background (B),

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 10/28/2014

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 157	F 323		

Assessment (A), Request (R) Communication Form and Progress Note dated 09/02/14 at 1:30 PM indicated Resident #94 was in the bathroom and a Nurse Aide (NA) was assisting resident with transfer from toilet to wheelchair. The notes further indicated Resident #94 lost his balance and fell over to his left side onto floor and the NA and a nurse assisted Resident #94 up to wheelchair and he had a small abrasion to his left elbow. The notes revealed Resident #94 appeared to be unsteady and needed more assistance with activities of daily living.

A review of a SBAR Communication Form and Progress Note dated 09/03/14 at 3:30 PM indicated Resident #94 was in the bathroom at 2:30 PM and a NA assisted resident to a standing position to transfer to wheelchair and the resident lost his balance and fell over to his left side. The notes further indicated staff assisted resident up to wheelchair and staff were aware to use 2 assist with transfers.

A review of a SBAR Communication Form and Progress note dated 09/19/14 at 1:45 PM indicated a nurse was called to the shower room by a NA. The NA reported Resident #94 had slipped out of his wheelchair to floor when she was toileting him.

A review of a physician's progress note dated 09/30/14 indicated in part a section labeled assessment and plan that Resident #94 demonstrated significant debility which warranted frequent monitoring by staff as well as preventive measures for complications such as falls with potential for injury or fractures. The notes further indicated to continue to provide a safe environment with preventive measures 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 10/28/2014

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 158	F 323		

support to optimize safety, function and quality of life.

During an interview on 10/17/14 at 11:27 AM Nurse #4 verified Resident #94 had a history of falls and it was the expectation for 2 Nurse Aides (NA's) to assist him with all transfers.

During an observation on 10/17/14 at 12:52 PM NA #3 transported Resident #94 in his wheelchair into the shower room on the 200 hall. No other NA's entered the room with NA #3 and Resident #94.

During an interview on 10/17/14 at 12:54 PM with NA #1 she stated usually only 1 NA transferred Resident #94 but sometimes he was unsteady and required 2 NA's during transfer.

During an observation on 10/17/14 at 1:08 PM Resident #94 was in the toilet in the shower room with NA #3 present. There was no other staff in the shower room.

During an observation on 10/17/14 at 1:10 PM NA #3 walked out of shower room while Resident #94 was still in the toilet in the shower room, closed the shower room door, walked toward the nurses station, stopped and spoke to another NA in the hallway, walked into the laundry across from the nurse's station and then walked down the hallway to a linen cart and picked up towels and washcloths and re-entered the shower room.

During an interview on 10/17/14 at 2:32 PM with NA #3 she confirmed she transferred Resident #94 to the toilet in the shower room by herself. She explained Resident #94 could stand on 1 leg and hold onto the bar with his good hand but his

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 10/28/2014

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 159 balance was a problem because he leaned to his left side. She further explained she had to push him a certain way to keep him up straight and it was a little tricky to keep him from falling. She stated she thought he was a limited 1 staff assist with transfers and she had not been told she couldn't leave him by himself in the shower room because he could use the call bell if he needed to call for assistance. During an interview on 10/17/14 at 2:38 PM Resident #94 was sitting in a wheelchair in the hallway outside his room and stated sometimes only 1 staff assisted him with transfers. He further stated he felt safe when 2 staff transferred him but he did not feel safe when only 1 staff transferred him. During an interview on 10/21/14 at 12:15 PM the Director of Nursing explained they had done resident teaching with Resident #94 to encourage him to use his own bathroom but he preferred to go to the bathroom in the shower room instead. He stated it was his expectation for 2 staff to assist Resident #94 with transfers and staff should not have left him alone in the shower room.	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		12/5/14

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 10/28/2014

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 325	Continued From page 160 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to identify and address unintended significant weight loss for 2 of 5 sampled residents. The facility did not implement care planned interventions to address significant weight loss and have timely implementation of recommended supplements for Resident #100 and did not identify significant weight loss and follow up on dietary recommendations for Resident #53. The findings included: 1. Resident #100 was admitted to the facility on 04/17/14. Her diagnoses included Parkinson's disease, history of traumatic brain injury, dementia, gastroesophageal reflux, hypothyroidism and hyperlipidemia. The initial Nutritional Evaluation dated 04/21/14 completed by the Dietary Manger (DM) noted her usual meal intake was 50% to 75% and she received a regular diet. This note stated her food preferences were obtained and review of this list revealed dislikes included eggs and she liked cold cereals. The admission Minimum Data Set (MDS) dated 04/24/14 coded her with usually being understood and usually understands, having some inattention and disorganized thinking, having moderately impaired cognition (scoring a 10 out of 15 on the	F 325	1. Resident #100 was assessed by the physician on 11/18/2014 with no new orders. Resident #53 was assessed by the physician on 11/18/201 with no new orders. 2. Residents with weight loss have the potential to be affected by this citation. Current residents were weighed 11/14/2014-11/18/2014 to establish a base line weight. A review of the last 90 days of dietary recommendations was completed 11/18/2014-11/21/14 by the Director of Clinical Services and/or Nursing Supervisor A review of residents currently receiving dietary supplements/fortified foods was completed on 11/18/2014-11/19/2014 Director of Clinical Services and/or Nursing Supervisor. The interdisciplinary team will meet weekly to discuss residents that trigger for weight loss. The Dietician will meet with the Director of Clinical Services and/or Nursing Supervisor upon completion of her duties to review progress and recommendations. 3. The Dietary Manager was in serviced on proper identification of weight loss, providing fortified foods per recipe,	

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 10/28/2014

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 325	Continued From page 161 brief interview for mental status), requiring supervision and set up for eating, having a poor appetite or overeating nearly every day, having no behaviors, and weighing 210 pounds at 5 feet 6 inches tall. The Registered Dietician's (RD) nutritional evaluation dated 04/27/14 noted Resident #100 was on a regular diet and her current intake ranged from 50% to 75%. The note included the recommendation to maintain her intake at greater than 50% for all meals. The note also included the need to monitor nutrition parameters and follow up as needed. A care plan was developed on 04/30/14 for the problem of potential for weight loss related to varied intake and diagnosis of dementia. The goal was for Resident #100 to maintain current nutritional status as evidenced by no more than a 7.4% weight loss through the next review. Interventions included to provide diet as ordered, assess meal intake and document, resident eats in her room, provide supplements as ordered, encourage good nutrition and hydration, dietician to eval as needed, monitor weights as ordered and monitor labs as ordered. Per Resident #100's weight record, on 05/06/14 she weighed 211.4 pounds and on 06/05/14 she weighed 190.6 pounds (a one month 9.84% significant weight loss). Review of the documented intakes for Resident #100 from 05/01/14 through 06/06/14 revealed there was no documentation related to how the resident's intake was for 13 breakfasts, 13 lunches and 10 dinners. In addition the intake reports noted Resident #100 ate less than 50% of	F 325	providing supplements as ordered, following dietary recommendations and following meal tickets by the Regional Director of Nutritional Services on 11/20/2014. Dietary Cooks were in serviced on following the menu for fortified foods on 11/20/2014 by the Regional Director of Nutritional Services.. Dietary Aides were in serviced by the Regional Director of Clinical Services on following meal tickets and providing fortified foods and supplements 11/20/2014-11/21/2014. Current residents will be weighed weekly until stable then monthly thereafter by certified nurse assistant. Residents with identified weight loss will be weighed weekly until stable. Care plans and kardex will be reviewed and updated with interventions as added. Dietary Manager and/or Executive Director will do Quality Improvement Monitoring of 5 residents meal trays at each meal that supplements/fortified foods are provided on will be monitored 5 times a week for 4 weeks, 3 times a week for 8 weeks 2 times a week for 8 weeks and 1 time a week for 4 weeks and/or substantial compliance is obtained. Quality Improvement Monitoring of dietary recommendations will be conducted weekly for 6 months and/or substantial compliance is obtained by the Director of Clinical Services and/or Nursing Supervisor. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for three months and/or until substantial	

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 10/28/2014

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 325	Continued From page 162 the meal for those days which were documented for 11 breakfasts, 7 lunches, and 9 dinners. Review of the physician's notes revealed he saw Resident #100 on 05/15/14 for anorexia and ordered lab work. On 05/19/14 the physician saw her again for anorexia and noted in his notes adjusted medications for potassium and hypothyroidism. On 05/22/14 nothing was noted about weight on this physician's visit. A nutritional evaluation dated 06/08/14 by the Dietary Manager (DM) noted that she needed tray set up assistance and her usual intake varied. The DM noted she was on a regular diet and food preferences were reviewed. Review of the food preference form dated 06/08/14 noted she still disliked eggs and now disliked cold cereal. The RD noted on 06/23/14 that she had a 9.8% wt loss in one month. The notation stated that weight loss would be beneficial to the resident at a slower rate and at adequate intake. The RD noted recommendations for a fortified meal plan and to monitor weight and intake and follow up as needed. No changes were made to the nutritional care plan. Interview with the RD at 10/14/14 at 4:20 PM revealed she never placed someone in a nursing facility on a weight loss program unless it was essential. She stated that weight loss could be beneficial for this resident and that she wanted Resident #100 to at least eat 50% of her meals. Interview with the District Dietary Manger on 10/14/14 at 4:20 PM revealed that there were recipes for fortifying foods and typically the hot cereal was fortified with more butter and sugar,	F 325	compliance is obtained by the Director of Clinical Services. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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 10/28/2014

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 325	Continued From page 163	F 325		

mashed potatoes were fortified with whole milk and butter and extra gravy would be considered fortifying. She further stated that in this facility, all fortified foods were added to the tray on top of the planned menus. For example if oatmeal was on the planned menu, then a resident on a fortified meal plan would get a bowl of regular oatmeal and a bowl of fortified oatmeal. She confirmed with the DM who joined this interview there was no way to discern the serving of fortified foods from the nonfortified foods served, ensuring the resident would eat a fortified serving before a nonfortified serving.

Per Resident #100's weight record, her weight continued to drop as documented on 07/07/14 when she weighed 185.8 pounds.

Resident #100 was seen for Speech Therapy (ST) from 06/03/14 through 07/13/14. Review of the ST discharge summary revealed the resident met the goals of consuming at least 50% for at least 2 meals for 5 consecutive days to prevent malnutrition and weight loss and to improve task recognition to 90% during therapeutic opportunities to prevent malnutrition and weight loss on 07/13/14. Discharge recommendations included for caregivers to set up resident at meals and the resident was to dine in the main dining room at meals.

Interview with the ST on 10/16/14 at 1:25 PM revealed that she worked with Resident #100 in order to increase the resident's intake. ST stated the breakfast meal was her worst meal for consumption and at times, she needed to sit with her, feed her and give her lots and lots of encouragement to eat. She stated Resident #100 consumed the best when she ate in the dining

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 10/28/2014

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 325	Continued From page 164	F 325		

room which was why she recommended her to eat in the dining room as often as she would agree to go.

Per Resident #100's weight record, her weights continued to drop as documented on 08/12/14 when she weighed 177.4 pounds (weight loss of 4.5 % in one month and 16.08% in 3 months).

The DM's nutritional review dated 08/13/14 noted this weight loss and noted she was on a regular diet, no supplements, and her intake varied. The note stated that sometimes Resident #100 ate 50% - 75% then at times would not eat more than a bite or two. This note indicated her albumin level was low and that the plan was to continue to monitor intake. No changes were made to the care plan.

The Director of Nursing provided weight committee notes dated 08/13/14 which indicated that she received a regular diet with fortified foods and was within her ideal body weight range. The corresponding interdisciplinary note dated 08/13/14 included plans to add ice cream and/or pudding to lunch and dinner trays. In addition the plan was to educate the resident about maintaining her current weight. No changes were made to the care plan.

The care planned intervention to monitor her intake was inconsistently documented as the meal intake records revealed multiple meals where her intake was not documented and/or she ate less than 50% as follows from 06/07/14 through 09/07/14:
*In June, breakfasts were not documented 7 times; lunch intakes were not documented 6 times; dinner intakes were not documented 7

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 10/28/2014

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 325	Continued From page 165	F 325		

times;
*In July breakfasts were not documented 17 times; lunches were not documented 20 times; dinner was not documented 11 times;
*In August breakfasts were not documented 14 times; lunches were not documented 15 times; dinner was not documented 4 times; and
*In September breakfasts were not documented 4 times; lunches were not documented 25 times; dinner was not documented 1 time.
Of those meals that were documented, Resident #100 was noted to eat 50% or less in 55 meals.

Resident #100's weight record noted her weight on 09/04/14 as 173.4 pounds (a loss of 9% in 3 months - since 06/05/14).

Review of the physician notes dated 09/04/14 revealed she was complaining of abdominal pain. He noted more laboratory testing was ordered. This note specified under the issue of weight loss that the resident "demonstrates acute changes that require increased support and frequent monitoring." Weight loss was noted as ongoing the plan was to continue to monitor and assess.

Laboratory testing dated 09/08/14 showed Resident #100's albumin level was low at 2.7 g/dl (normal range starting at 3.5 g/dl) and the total protein was low at 5.0 g/dl (normal range starting at 6.0 g/dl)

On 09/08/14 the RD noted a 9% weight loss in 3 months. He noted Resident #100 was on a fortified meal plan and ate approximately 50%. The RD recommended a house supplement 60 milliliters 4 times per day and follow up as needed. This was written on a recommendation form which was dated 09/08/14. The physician's

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 10/28/2014

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 325	Continued From page 166	F 325		

order was not written for the house supplement until 09/21/14 and the house supplement was not started per the Medication Administration Record until 09/22/14.

Interview with the RD #1 on 10/14/14 at 4:20 PM revealed there were 2 dieticians who worked together and came to the facility. RD #1 stated that fortified meals were not physician ordered but just were communicated with the kitchen and placed on the tray card. Supplements were physician ordered and for Resident #100's physician's request, a supplement order would be written by the RD. RD #1 stated that although she had informed the other dietician of the need to write the supplement order, the order was not written and/or responded to until 09/21/14. Upon follow up interview on 10/14/14 at 5:51 PM, RD #1 stated that all dietician's recommendations were written on a form and provided to the dietary manager and the DON for follow up as a double check system to ensure interventions were in place.

Interview with DON on 10/17/14 at 2:45 PM, revealed the facility had weekly weight committee meetings to discuss residents. He stated the RD left him and the dietary manager recommendations of those residents reviewed. He stated that at the weight committee meetings, the team had the RD's recommendations and the chart to ensure all recommendations were acted upon. He then provided the weight committee meeting notes dated 09/09/14 which showed the supplement recommendation for Resident #100. The DON could not explain how the supplement recommendation was not ordered from the physician until 9/21/14 as the team was aware of this recommendation.

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 10/28/2014

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 325	Continued From page 167	F 325		

Review of Resident #100's meal intake records continued to reflect incomplete intake documentation as follows from 09/08/14 through 10/11/14:
*23 breakfast intakes were not documented and 7 documented times she ate less than 50%;
*23 lunch intakes were not documented and 7 documented times she ate less than 50%; and
*7 dinner intakes were not documented with 8 documented times she ate less than 50%.

Interview with Nurse Aide (NA) #4 on 10/15/14 at 2:07 PM revealed the computer on the hall where care provided by nurse aides was documented, had been broken for at least 6 months and in order to document staff had to go to another hall. She further explained that staff were not allowed to leave the hall without another staff member being present on the hall.

Resident #100's latest laboratory test dated 10/08/14 revealed her albumin continued to drop and now was 2.1 g/dl.

Per Resident #100's weight record, her weight continued to drop as documented on 10/12/14 at 167.8 pounds (20% significant weight loss in 6 months).

Observations on 10/14/14 at 7:59 AM revealed NA #3 attempted to feed the resident breakfast while she was in bed. She would not eat but a couple of bites stating she felt nauseated. She did not touch the eggs on her tray which were listed as a dislike on her tray card. Per the intake records, she ate between 25 and 50% of this meal.

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 10/28/2014

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 325	Continued From page 168	F 325		

On 10/15/14 at 5:36 PM, Resident #100 had a dinner tray in her room and the tray was untouched. She did have a serving of mashed potatoes. She stated she could not eat a bite and wanted something for acid reflux. She further stated the doctor needed to see her because she could not eat. Per the intake records, she ate between 50 and 75% of the meal.

On 10/16/14 at 8:20 AM, Resident #100 was observed eating breakfast while in bed which consisted of sausage, cold cereal, pancakes. The tray card indicated she should have fortified foods. At 8:39 AM she had chewed and spit out a bite of sausage and stated she could not eat any more. She ate less than 25% and did not receive fortified food.

On 10/17/14 at 8:30 AM, Resident #100's eaten tray was observed with NA #1 who served her food. On the tray were eggs (a dislike), english muffin, cold cereal and bacon. NA #1 confirmed there was no oatmeal on the tray. The DM stated on 10/17/14 at 11:47 AM that staff had requested eggs for Resident #100 this morning and she did not get the fortified oatmeal because the resident preferred cold cereal. DM continued that if a resident did not like hot cereal which was the fortified food for the breakfast trays, then the DM stated she had no other fortified items to send on breakfast trays. On 10/17/14 at 12:24 PM, NA #1 who served the resident breakfast this am stated the eggs were on the tray at time of service and she did not request eggs.

On 10/17/14 at 12:00 PM Resident #100 was observed in the dining room. She was served the regular meal of fish and tater tots. She did not have the fortified food of mashed potatoes on 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 10/28/2014

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 325	Continued From page 169	F 325		

plate. When asked, the DM could not explain why the resident did not receive the fortified food item at this meal.

2. Resident #53 was admitted to the facility on 04/30/12 with diagnoses including Alzheimer's disease, dementia, and dysphagia. An annual Minimum Data Set (MDS) dated 04/16/14 revealed Resident #53 had severely impaired cognition, was totally dependent on staff for eating, and noted a weight of 121 pounds. Review of a quarterly MDS dated 07/14/14 revealed Resident #53 had severely impaired cognition, was totally dependent on staff for eating, and noted a weight of 119 pounds.

Review of a care plan dated 04/26/13, and last reviewed on 07/31/14, stated Resident #53 was at risk for weight loss related to dementia and varied intake. The goal was for the resident to maintain her current nutritional status as evidenced by no more than a 7.5% (percent) weight loss through the next review on 10/31/14. Interventions included: assess meal intake and assist as needed, provide supplements as ordered, monitor weights as ordered, and Registered Dietitian (RD) to evaluate as needed. The care plan was updated on 04/27/14 to include increasing the house supplement to three times a day.

Review of the medical record revealed the following recorded weights:
03/07/14- 127.4 pounds
04/02/14- 121.6 pounds
05/06/14- 121.2 pounds
06/05/14- 122.8 pounds

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 10/28/2014

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 325	Continued From page 170 07/07/14- 119.2 pounds 08/06/14- 114.8 pounds 09/04/14- 111.2 pounds 10/14/14- 109.8 pounds Review of a nutrition progress note completed by the RD on 04/07/14 revealed Resident #53's current weight was 121.6 pounds which reflected a 4.55% weight loss in 30 days. The RD noted Resident #53's weight was 127.4 pounds in March 2014 with a 5.8 pound weight loss in 30 days. The RD recommended to increase the resident's house supplement to 60 cc (cubic centimeters) three times a day. Review of a nutritional review completed by the Dietary Manager (DM) on 07/14/14 stated Resident #53 consumed 75% to 100% of her meals and 100% of her supplement. The DM noted a current weight of 119.2 pounds with no significant weight loss at that time. Further review of nutritional reviews and nutritional progress notes revealed no further documentation by the DM regarding weight loss or dietary supplements. Review of a nutrition progress note completed by the RD on 09/21/14 revealed Resident #53's current weight was 111.2 pounds which reflected a 3.6 pound weight loss in 30 days. The RD further noted Resident #53 had lost 9.45 % in 90 days (3 months) and 12.72 % in 180 days (6 months). The RD indicated Resident #53's diet order was regular puree with honey thick liquids and house supplement 60 cc three time a day. The RD recommended Prostat (high calorie/complete liquid protein supplement) daily due to recent skin concerns, enriched meal plan, and to increase the house supplement to 90 cc	F 325		

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 10/28/2014

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 325	Continued From page 171	F 325		

three times a day.

Observations of Resident #53 during meals revealed the following:
- On 10/14/14 at 8:02 AM Resident #53 was observed in the dining room with her eyes closed. Staff attempted to wake her up to eat for 20 minutes but were not successful.
- On 10/14/14 at 12:25 PM Resident #53 was alert and seated at a dining room table with a nurse aide sitting next to her. Resident #53 was totally dependent on staff with eating. Resident #53 accepted 50 % of her lunch.
- On 10/17/14 at 8:50 AM Resident #53 was alert and seated at a dining room table with a nurse aide sitting next to her. Resident #53 was totally dependent on staff with eating. Resident #53 accepted 75 % of her breakfast.

An interview was conducted with the Director of Nursing (DON) on 10/15/14 at 3:30 PM. The DON stated weight meetings were held every Tuesday and the Assistant Director of Nursing (ADON), MDS Coordinator, and DM attended. The DON indicated monthly weights and percentages were reviewed during the meeting to identify residents with 5% weight loss in one month, 7.5% weight loss in 3 months, and 10% weight loss in 6 months. The DON confirmed Resident #53 was discussed during the weight meeting on 09/23/14 and the RD recommendations from 09/21/14 were noted. The DON further stated Resident #53 had not triggered for significant weight loss at the 09/23/14 weight meeting but he would review his information. The DON reviewed Resident #53's medical record at the time of the interview and confirmed no order had been written for the RD recommendations noted in the nutrition progress

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 10/28/2014

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 325	Continued From page 172	F 325		

note on 09/21/14.

A telephone interview with the RD on 10/16/14 at 10:55 AM revealed she would have faxed her recommendations for Resident #53's significant weight loss to the Physician for his approval before she left the facility on 09/21/14. The RD stated she also leaves a copy of the recommendations with the Administrator, DON, and the DM.

During a follow up interview on 10/16/14 at 3:00 PM the DON stated Resident #53's significant weight loss was not addressed during the 09/21/14 weight meeting. The DON further stated he was not certain they had a copy of the monthly weights and percentages for the weight meeting on 09/23/14, which would have reflected Resident #53's significant weight loss, because the DM did not attend the meeting. The interview further revealed the RD's nutrition progress note dated 09/21/14, which noted significant weight loss, was not reviewed during the weight meeting on 09/23/14. The DON indicated there were currently no parameters for follow up of dietary recommendations faxed to physicians. Resident #53's monthly weights from March 2014 through October 2014 were reviewed during the interview and the DON confirmed Resident #53 experienced continued weight loss since the 09/23/14 weight meeting.

An interview with Resident #53's Physician on 10/16/14 at 4:53 PM revealed he received a large volume of faxes to his office daily and could not specifically recall the fax from the RD with dietary recommendations on 09/21/14 or when he replied to the fax. The Physician stated when he came to the facility on 10/14/14 the nurse did not

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 10/28/2014

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 325	Continued From page 173 mention weight loss being an issue when they discussed Resident #53. An interview was conducted with the DM with the DON present on 10/17/14 at 10:20 AM. During the interview Resident #53's monthly weights and percentages which calculated percentage of weight loss for March 2014 through September 2014 were reviewed. The DM and the DON both confirmed Resident #53 should have triggered for a significant weight loss of 12.72% in 6 months in September 2014. The DM stated she did not attend the weight meeting on 09/23/14 but typically printed a copy of the monthly weights and percentages for the past 6 months for all residents and gave copies to the DON and ADON for the weekly weight meeting. The interview further revealed the DM did not need a physician's order for fortified foods but could not verify when she added these to Resident #53's diet because she did not document regarding this in the medical record.	F 325		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328		12/5/14

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 10/28/2014

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 328	Continued From page 174 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure a compressed oxygen cylinder during transport during two 2 of 2 observations: The findings include: Review of the facility procedure for Handling, Storage and Transporting Compressed Gases effective date of 01/01/2012 with a revised date of 09/04/14 revealed compressed gases and cylinders should always be transported in 2 hands or with a cart or hand truck, with the cylinder secured, cylinders were to have proper caps when not in use and during transport and rough handling, dropping and dragging of cylinders should be avoided. On 10/15/14 at 9:08 AM the Maintenance Director was observed carrying a compressed oxygen cylinder by the neck of the cylinder one handed from the hallway into empty oxygen cylinder storage room located in front of the nurse's desk. A compressed oxygen cylinder was observed to prop the door to the storage room open with 6 more oxygen cylinders sitting on the floor in front of the storage room that were also carried into the empty cylinder storage room, one handed, by the Maintenance Director. The Maintenance Director was interviewed and stated he did not think about using a cart to secure the empty compressed oxygen cylinders for transportation. He stated he should have used a cart to transport the compressed oxygen cylinders. On 10/16/14 at 7:33 AM the Assistant Director of Nursing (ADON) was observed carrying a compressed oxygen cylinder at chest level out of the storage room located in front of the nurse's desk. The ADON placed the compressed oxygen cylinder on the floor, unsecured, in front of the	F 328	1. No residents were injured related to this citation. The Maintenance Director was in serviced on proper storage and transport of the oxygen cylinders using the wheeled cart on 11/20/2014 by the Regional Director of Clinical Services. The Assistant Director of Clinical Services was in serviced on proper transport of oxygen cylinders using the wheeled cart by the Executive Director on 11/21/2014. 2 All residents have the potential to be affected by this citation. Observations for improper transport and storage of oxygen cylinders were completed 11/20/2014-11/21/2014 by the Executive Director. 3. Licensed nurses, certified nurse assistants, maintenance assistant, therapy staff were in serviced by the Director of Clinical Services on transporting cylinders via wheeled cart and storage of oxygen cylinders 11/10/2014-12/04/2014. The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records), will perform Quality Improvement monitoring for the proper transport of oxygen cylinders 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks and/or substantial compliance is obtained.	

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 10/28/2014

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 328	Continued From page 175 nurse's desk where the resident's wheel chair bumped the compressed oxygen cylinder. At 7:34 AM the ADON was observed holding the full oxygen tank at chest level while 3 other staff members were trying to attach the canvas oxygen cylinder holder to the back of the resident's wheelchair. At 7:36 AM the Director of Nursing (DON) was observed giving the ADON a hand held rolling cart for the compressed oxygen cylinder she was holding. The ADON secured the oxygen cylinder into the hand held rolling cart. An interview was conducted on 10/20/14 at 11:19 AM with the Director of Nursing. He reported compressed oxygen cylinders should be secured and transported in the hand held rolling cart. He further stated a compressed oxygen cylinder should never be used to prop a door open or carried by the neck.	F 328	4 The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		12/5/14

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 10/28/2014

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 329	Continued From page 176 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility administered medications without supporting medical diagnoses for 1 of 7 residents reviewed for unnecessary medications. (Resident #101). The findings included: 1. Resident #101 was admitted to the facility 08/15/14 with diagnoses which included cerebral vascular accident (CVA {stroke}) in February of 2014, left sided hemiplegia (paralysis), depression, late effects of cerebrovascular disease (a group of brain dysfunctions related to the blood vessels), and an unspecified mental or behavioral problem. An admission Minimum Data Set (MDS) dated 08/26/14 indicated Resident #101's cognition was moderately impaired. The MDS specified the resident's speech was unclear, sometimes he was understood, and sometimes he understood others. The MDS further specified the resident experienced mild depression, delusions, displayed physical behavior symptoms directed toward others 4 to 6 days and other behavioral symptoms not directed toward others 1 to 3 days during the past 2 weeks. The MDS identified the	F 329	1. Resident #101 no longer resides at the facility. 2. All residents have the potential to be affected by this citation. An audit of current resident medications for a supporting diagnosis was completed 11/24/2014-12/04/2014 by the Director of Clinical Services and/or Nursing Supervisor. 3. Licensed nurses were in serviced by the Director of Clinical Services on making sure medications have a supporting diagnosis 11/24/2014-12/04/2014. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of newly written physician orders for supporting diagnosis of medications 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance	

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 10/28/2014

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 329	Continued From page 177	F 329		

behaviors exhibited by the resident put the resident at risk for injury, interfered with resident care and social activities, put others at risk for injury, intruded on the privacy of others, and disrupted care or living environment. The resident also demonstrated wandering daily that intruded on the privacy of others. The resident's functional status MDS assessment specified the resident required extensive staff assistance of 2 for bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. The MDS recorded Resident #101 received antipsychotic medications 6 days in a 7 day period and antianxiety, antidepressant, and anticoagulant medications 7 days in the same period. The MDS specified the resident's goal was to remain in the facility and not return to the community.

A review of physician's orders dated 08/15/14 revealed upon admission, Resident #101 was receiving the following psychotropic medications: Celexa (antidepressant) 20 milligrams (mg) daily, Depakote (antiepileptic) 500 mg twice a day, Ativan (antianxiety) 1 mg twice a day, Haldol (antipsychotic) 1 mg at bedtime, and Benadryl (antihistamine) 25 mg at bedtime.

A review of a physician's progress note dated 08/21/14 revealed the resident continued to demonstrate episodes of combativeness, but nurse's notes indicated staff told him they could not help with him if he continued to hit them, and he stopped. The MD documented Haldol and Benadryl dosages would be decreased then discontinued over a period of a couple of weeks. This progress note also listed the psychotropic medications as they were observed on the physician's orders dated 08/15/14. Diagnoses documented on this progress note where noted to

Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.

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 10/28/2014

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 329	Continued From page 178	F 329		

be unchanged from previous MD progress note dated 08/19/14.

A review of SW documentation dated 08/22/14 revealed the SW made a request to the Mobile Crisis agency (a state division of mental health that provided professionals that assist people experiencing a crisis due to mental health) for help in getting treatment for Resident #101.

A physician's order dated 08/26/14 provided instructions to increase Depakote to 500 mg every 8 hours and start Klonopin (an antianxiety) 1 mg every 8 hours alternate with Depakote. No diagnoses were given for the addition of Klonopin.

On 08/27/14, documentation by the SW revealed the resident did not have a psychiatric diagnosis.

A review of a request for a physician's visit dated 09/08/14 and signed by Nurse #14 revealed Resident #101 had been noted over the weekend with increased anger outbursts, striking staff, and threatening other staff with leg rest part of his wheelchair.

A review of a physician's progress note dated 09/18/14 revealed the resident was seen last month for increase in behavioral disturbances. The Depakote was increased to 500 mg 3 times a day. Haldol and Benadryl were discontinued gradually. Ativan was discontinued and replaced with Klonopin (antianxiety) 1 mg 3 times a day. The physician's plan was to continue to be monitor for signs or symptoms of changes that may reflect exacerbation or complications. No additional diagnoses were provided on this progress note.

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 10/28/2014

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 329	Continued From page 179	F 329		

A review was conducted of a physician's progress note dated 09/30/14 and signed by the MD. The note specified Resident #101 was readmitted to the facility 09/26/14 following a hospitalization that started 09/23/14 for behavioral disturbance with combativeness. The MD also documented he had received a call on 09/29/14 regarding continued disruptive behaviors. The MD's plan specified to continue Depakote and Klonopin with Geodon (antipsychotic) and Ativan as needed and he would add Seroquel (antipsychotic) 50 mg twice a day. No new diagnoses were noted on this progress note.

A review of the LCSW note dated 10/02/14 revealed Resident #101 was evaluated. A new diagnosis of intermittent explosive disorder was provided by the LCSW. The LCSW's evaluation contained the resident had poor frustration tolerance. He struggled in making his needs known. When frustrated he could become violent. The resident hits and bites staff. The LCSW documented this resident was at risk to harm others.

A review was conducted of a physician's progress note dated 10/02/14 and signed by the MD. The MD documented Resident #101 experienced an acceleration of combativeness with no response to discussion/counseling. The resident has demonstrated potentially dangerous behavior toward staff, including hitting and biting. Placement in an appropriate facility equipped for this type of behavior was being sought. In the meantime, Seroquel will be increased to 100 mg twice a day. No new diagnoses were observed on this progress note.

A review was conducted of a physician's progress

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 10/28/2014

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 329	Continued From page 180	F 329		

note dated 10/07/14 and signed by the MD. The MD specified following the increase in the Seroquel dosage, Resident #101's behavior has been somewhat improved with decreased combativeness and agitation. He still occasionally strikes out and becomes irritated, but this was less often and less severe. No new diagnoses were provided on this progress note.

A review of a physician's order dated 10/07/14 revealed instructions were provided for Haldol 1 mg intramuscularly every 2 hours as needed for agitation.

An interview was conducted with the Administrator on 10/27/14 at 1:12 PM. The Administrator stated the representative from Mobile Crisis viewed Resident #101 with no psych diagnosis and with behaviors resulting from a stroke causing traumatic brain injury.

An interview was conducted with the MD on 10/28/14 at 9:04 AM. The MD stated his plan of treatment when Resident #101 was admitted to the facility was to try to get this resident in a better place by medications that sedate him, then back off medication doses until he found the right combination that prevented the combativeness and striking out. The MD further stated he had talked with the resident's family. The family reported this resident had been very independent throughout his life. He did not like to accept help from anyone. The MD stated the resident's frustration with difficulty making himself understood and depending on others for everything contributed to his disruptive behavior. The MD stated the Haldol and Benadryl doses were tapered and then discontinued. Other medications that he felt were better suited were

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 10/28/2014

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

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F 329	Continued From page 181 put in place. An additional interview with the MD on 10/28/14 at 10:40 AM revealed he had discovered the diagnosis of intermittent explosive disorder written on the LCSW report of 10/02/14. An interview was conducted via phone with the Director of Crisis Management (Mobile Crisis) on 10/28/14 at 12:54 PM. The Director of Crisis Management stated Resident #101 had not had a mental diagnosis. A review was conducted of a progress note written by the MD and 10/28/14. This note included a diagnosis of impulse control disorder. The note also specified Resident #101's unpredictable behaviors threatened the safety of other residents and staff. The note further specified an increase in Depakote to 750 mg three times a day would be considered and a possible transfer to another facility was anticipated in the near future.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility medication rate was greater than 5 % as evidenced by 3 medication errors out of 25 opportunities, resulting in a medication error rate of 12% for 2 of 9 residents observed during	F 332	1. Resident #60 wasn□t injured related to this citation. Resident #60 was assessed by the physician on 11/18/2014 with new orders noted. Resident #55 wasn□t injured related to	12/5/14

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CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

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F 332	Continued From page 182 medication pass. (Residents #60 and #55). The findings included: 1. Resident #60 was readmitted to the facility on 09/21/14 with diagnoses which included diabetes mellitus, heart failure, high blood pressure, high cholesterol and anxiety. A review of Resident #60's medical record revealed monthly physician's orders dated 10/01/14 through 10/31/14 indicated Novolog Insulin 10 units subcutaneously before meals at 7:30 AM; 11:30 AM and 4:30 PM. During an observation on 10/16/14 at 8:19 AM Nurse #16 was observed as she administered Novolog insulin subcutaneously to Resident #60 while the resident ate breakfast. During an interview on 10/16/14 at 4:20 PM Nurse #16 verified Resident #60 was eating breakfast when she gave Novolog Insulin to her earlier that morning. She stated she did the best she could to give it before meals and sometimes she could give the insulin before breakfast and sometimes she had to give it during breakfast. She stated she knew Novolog insulin should be given before breakfast but it was difficult to do because if she gave it early it conflicted with the morning shift report and if she gave it after she started her morning medication pass she had to give it during breakfast. She stated she had not talked with anyone in nursing administration about how to administer insulin before breakfast trays were delivered. During an interview on 10/21/14 at 9:15 AM the physician who was also the facility Medical	F 332	this citation. Resident #55 was assessed by the physician on 11/18/2014 with no new orders noted. Nurse #16 was in serviced by the Director of Clinical Services on following physician orders and proper administration of medications through an enteral tube on 11/22/2014. 2. Residents who have an enteral tube and who receive insulin have the potential to be affected by this citation. An audit of residents receiving insulin and medications via an enteral tube was completed 11/21/2014-12/4/2014 by the Director of Clinical Services and/or Nursing Supervisor. During the clinical meeting medication administration times for insulin will be discussed to make sure that times given correlate to manufacture recommendation related to time of meals. Observation of Licensed nurses administering medications to include insulin□s and enteral tube medications 11/24/2014-12/4/2014. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses on medication administration of insulin using right resident, right dose, right time, right route and time, following physician orders and administering medications via an enteral tube 11/24/2014-12/4/2014. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of 2 licensed nurses per shift per day for proper	

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CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

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F 332	Continued From page 183 Director stated it was his expectation for nurses to follow his orders as he had written them and if they had questions, they should get clarification if they did not understand the orders. He stated Novolog insulin should be given before meals as he had ordered it. During an interview on 10/21/14 at 12:15 PM the Director of Nursing stated it was his expectation for nursing staff to administer medications according to the physician's orders which included giving insulin before meals as it was ordered. 2. A review of a facility policy titled Medications - Administration via Enteral Tube (a tube placed through the abdomen into the stomach to provide food or medication) with a revised date of 08/08/14 indicated in part a section titled procedure: If a medication was able to be crushed, finely crush each medication with pill crusher and pour powder into a medication cup with 5 - 15 cc (cubic centimeters) of water and dissolve. If liquid, pour the correct amount per the physician order into a medication cup. There should be one medication per cup. Pour one, individual liquefied medication in the syringe, and allow gravity to drain medication into the stomach, followed by at least 15 cc (or physician order if different) of water in between each medication. Resident #55 was re-admitted to the facility on 07/08/14 with diagnoses which included thyroid disease, diabetes mellitus, vitamin deficiency, anemia, high blood pressure, heart disease, esophageal reflux; difficulty swallowing and a stomach tube. A review of monthly physician's orders dated	F 332	medication administration 5 times a week for 1 month, 3 times a week for 2 month, 2 times a week for 2 month and 1 time a week for 1 months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

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CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

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F 332	Continued From page 184 10/01/14 through 10/31/14 indicated the following medications in part: Cerovite 9 milligrams (mg)/15 milliliters (ml) by tube every day Zoloft (Sertraline) 100 mg by tube every day Carafate 20 ml (2 Gm) by tube twice daily Coreg (Carvedilol) 6.25 mg by mouth every 12 hours Vitamin D3 5000 units by tube every 8 hours Baclofen 10 mg by tube three times a day Colace liquid 10 ml by tube three times a day Reglan 5 mg by tube four times a day Levsin (Hyoscyamine) 0.125 mg (2) tabs (0.25 mg) by tube every 4 hours During an observation on 10/16/14 at 8:36 AM Nurse #16 was observed as she prepared medications at a medication cart to administer through Resident #55's stomach tube. Nurse #16 crushed Sertraline 100 mg tablet into a plastic medication cup, then crushed Coreg 6.25 mg tablet in a separate plastic medicine cup, then crushed Vitamin D3 5000 units (2) tablets into a separate plastic medication cup, then crushed Baclofen 10 mg tablet into a separate plastic medication cup and then crushed Levsin 0.125 mg (2) tablets into a separate plastic medication cup. Nurse #16 then poured approximately 5 cc water into each of the medication cups. She then poured Cerovite liquid 15 ml into a plastic medication cup, then Carafate 20 ml liquid into a separate plastic medicine cup, then Colace 10 ml liquid into a separate plastic medicine cup and Reglan 5 mg into a separate plastic medicine cup. Nurse #16 then carried the medication cups into Resident #55's room. She disconnected tubing from a feeding pump and checked placement of the stomach tube with a stethoscope and syringe and poured 30 cc of	F 332		

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

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

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F 332	Continued From page 185	F 332		

water into a syringe that was connected to Resident #55's stomach tube and allowed the water to flow through the tube by gravity. She then poured each of the plastic medicine cups that contained the crushed pills one after the other into the syringe that was connected to the stomach tube but did not flush with water between each medication. She then poured each cup of liquid medication with approximately 5 ml of water after each one into the stomach tube.

During an interview on 10/16/14 at 8:54 AM Nurse #16 stated she had made a mistake and gave a duplicate dose of Vitamin D because it had already been given at 6:00 AM that morning. She stated she should have caught that it had already been given when she checked the Medication Administration Record but she missed it. Nurse #16 also verified she did not flush with water between the crushed medications and only flushed after each liquid medication that she poured into the tube. She stated she did not flush between the crushed pills because she had added water to each of the cups but she flushed between the liquid medications because she had not added any water to those cups.

During an interview on 10/21/14 at 9:15 AM the physician who was also the facility Medical Director stated it was his expectation for nurses to follow his orders as he had written them. He further stated Resident #55's stomach tube should be flushed between medications because particles of the crushed medications collected in the tube and clogged the tube. He stated Resident #55 had not had issues with fluid overload so water should have been used to flush the medications to prevent the tube from clogging.

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

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CLAY COUNTY CARE CENTER	86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904

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F 332	Continued From page 186 During an interview on 10/21/14 at 12:15 PM the Director of Nursing stated it was his expectation for nursing staff to administer medications according to the physician's orders and they should follow facility policy to flush medications with water between medications when they were administered through a stomach tube.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transcribe and administer an antibiotic per physician orders for 1 of 7 residents sampled for medication review. (Resident #61). The findings included: 1. Resident #61 was admitted to the facility on 09/28/12 and most recently readmitted on 09/14/14. His diagnoses included anemia, gastric intestinal bleeding, and urinary tract infections. Resident #61 was hospitalized from 09/08/14 to 09/14/14 for an upper gastrointestinal bleed and nausea and vomiting. He was diagnosed while in the hospital with diverticulosis, probable diverticulitis and an urinary tract infection secondary to Staph Aureus. Physician telephone orders dated and signed by the physician on 09/14/14 included Metronidazole	F 333	1. Resident #61 was assessed by the Physician on 11/18/2014 with new orders noted. 2. All residents that take antibiotics have the potential to be affected by this citation.Current residents receiving antibiotics orders were verified as transcribed correctly to the medication administration record 11/21/2014-12/4/2014 by the Director of Clinical Services and/or Nursing Supervisor. 3. The Director of Clinical Services in serviced licensed nurses on transcribing orders correctly to the medication administration record 11/24/2014-12/4/2014. The Director of Clinical Services and/or Nursing Supervisor will perform Quality	12/5/14

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

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

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F 333	Continued From page 187 (also known as Flagyl an antimicrobial agent) 250 milligrams (mg) was to be administered 4 times a day for 7 days. These orders were signed as being verified by Nurse #12. Review of the Medication Administration Record MAR), Metronidazole 250 mg was written to be given "qid" (4 times a day) for 7 days. There were only 2 times (9:00 AM and 4:00 PM) that were written for the medication to be given. Review of the MAR revealed the medication was actually signed off as being given twice per day for 14 days. Interview on 10/20/14 at 1:49 PM with Nurse #12 revealed that this resident was readmitted on a weekend. She verified the orders with the physician. She stated that she did not transcribe the orders to the MAR on that date. she further explained that at that time there was a unit coordinator who transcribed the orders. Nurse #12 stated the medication was to be given 4 times per day for 7 days. On 10/22/14 at 9:00 AM the Assistant Director of Nursing stated the Metronidazole was transcribed incorrectly. She further stated the facility had noted that night shift was not accurately checking the MARs and they were reeducated on 09/20/14 and 09/21/14 however, this error was not identified. Interview on 10/21/14 at 11:30 AM with the Director of Nursing revealed the transcription was incorrect and the medication should have been given 4 times a day for 7 days and instead was given 2 times a day for 14 days. He further stated that this error was going to be handled as a medication error.	F 333	Improvement monitoring of physician orders to ensure they were transcribed accurately to the medication administration record using the copied orders from morning clinical meeting 5 times a week for 1 month, 3 times a week for 2 month, 2 times a week for 2 month and 1 time a week for 1 months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

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F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to post the required nurse staffing data for 5 of 7 days.	F 356	1. No residents were injured related to this citation. 2. All residents have the potential to be	12/5/14

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

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F 356	Continued From page 189 The findings included: On the first day of survey, Sunday 10/12/14 at 12:12 PM, observation of the posted nurse staffing data, posted at the main nursing station, was dated 10/10/13 (sic should be year 2014). This indicated that the nurse staffing data was not changed since Friday 10/10/14. On 10/13/14 at 8:45 AM, the posted nurse staffing data was observed changed for the correct date of 10/13/14. On 10/15/14 at 10:33 AM and at 3:22 PM, the posted nurse staffing data was observed as being from the day before which was dated on 10/14/14. Observations on 10/16/14 at 6:45 AM, 7:46 AM and 3:34 PM, revealed the nurse staffing data for 10/14/14 remained posted by the nursing station. On 10/17/14 at 8:26 AM, the posted nurse staffing data was observed to still be dated 10/14/14. At this time the Director of Nursing (DON) was interviewed. DON stated that he was responsible for posting the daily nurse staffing data after the staffing coordinator gave him the information to post. He stated he changed the posting daily and on the weekends the unit manager or liaison was responsible for filling out the form and posting the nurse staffing data based on the schedule. DON confirmed he had not posted the correct information each day of the week because surveyors were in the building. He could not explain the missing data from the weekend.	F 356	affected by this citation. 3. The Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Scheduler were in serviced by the Regional Director of Clinical Services on the posting of hours daily. The Director of Clinical Services will perform Quality improvement Monitoring 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks, 1 time a week for 4 weeks and/or substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	
F 371	483.35(i) FOOD PROCURE,	F 371		12/5/14

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 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371 SS=F	Continued From page 190 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, staff interviews, and documentation review the facility failed to ensure the minimal required temperature was obtained for the dishwashing machine's final rinse cycle. In addition, the facility failed to remove dented cans in dry storage room placed on the shelf in the ready for use area. The findings included: 1. An initial tour of the kitchen was made on 10/12/14 at 11:43 AM. Observations of the dish washing machine revealed the machine's final rinse cycle temperatures fluctuated between 112 and 120 degrees Fahrenheit. On 10/14/14 at 12:23 PM, one dietary aide was observed washing dishes in the kitchen's dish machine. The dietary aide was able to verbalize the desired temperature for the wash and rinse cycles were supposed to be 120 degrees Fahrenheit (F). However, the temperature logs did not have daily temps recorded by staff, to indicate that the dish machine was being	F 371	1. No resident was affected by this citation. The dented cans were removed from the dry storage area by the dietary manager on 10/17/2014. The Maintenance Director increased the temperature to the boiler on 10/15/2014. Combustion and Control Solutions INC serviced the boiler on 10/28/2014. 2. All residents have the potential to be affected by this citation. Observations for dented cans in the dry storage room were completed on 11/20/2014-11/21/2014 by the Executive Director. Observation of the temperatures recorded on log to be at minimum of 120 degrees on the dish machine was completed 11/20/2014-11/21/2014 by the Executive Director. 3. Dietary Manager, Dietary Aides, Dietary Staff were in serviced on	

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

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

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F 371	Continued From page 191 monitored with the recommended final rinse temperature. The Dietary Manager (DM) and the Facility's Corporate District Dietary Manager were present for the observation and confirmed the dish machine's final rinse temperature should be a minimum of 120 degrees F. The DM stated the dish machine was a low temp unit and the final rinse cycle temps at this time as follows: 1st time-final rinse cycle temp was 104 2nd time---final rinse cycle temp was 118 3rd time---final rinse cycle temp was 120 A copy of the October, 2014 dish machine temperature log was reviewed. Instructions on the log read: log wash temperature, final rinse temperature, and the sanitizer concentration strength when washing dishes. The log specified that the dish machine temperature was required to be greater than or equal to 120 degrees Fahrenheit for the final rinse cycle. The following dates on the dish machine temperature/sanitizer log had entries recorded and initialed by the dietary staff directly involved in the dishwashing process. The log indicated the final rinse cycle temperatures as follows: a) 10/02/14 dinner meal final rinse at 100 degrees F. b) 10/05/14 dinner meal final rinse at 100 degrees F. c) 10/13/14 breakfast meal final rinse at 100 degrees F. A review of the dish machine's temperature log from May 2014 through October 2014 revealed 63 times out of 168 days the final rinse cycle temperature was recorded by staff at less than	F 371	recording the temperatures of dish machine, notifying maintenance if temperature is not maintained and go to Styrofoam until fix on removing dented cans from the shelves with the other cans by the Executive Director 11/21/2014-11/24/2014. The Dietary Manager and/or Executive Director will do Quality Improvement Monitoring of the recording of the dish machine temperatures 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 8 weeks and/or until substantial compliance is obtained. The Dietary Manager and/or Executive Director will do Quality Improvement Monitoring of the proper storage of dented cans 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 8 weeks and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Dietary Manager for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse	

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 10/28/2014

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(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	Continued From page 192 120 degrees Fahrenheit. On 10/15/14 at 8:43 AM an interview was conducted with the Dietary Manager (DM). She stated she expected the dish machine temperatures to be 120 degrees Fahrenheit or greater for the wash cycle and the final rinse cycle. She further stated she was unaware of any problems with the temperatures of the dish machine. She confirmed the final rinse cycle was not at least 120 degrees each time the dishes were run through the machine but expected the dietary staff to run the dishes through the machine again or until the machine's final rinse cycle temperature reached a minimum of 120 degrees F. On 10/17/14 at 11:35 AM a telephone interview was conducted with the Ecolab Representative. He stated he was made aware the dish machine temps were not reaching the 120 degrees. He indicated he had been to the facility 2 to 3 times in the past couple of weeks related to the temps of the dish machine and each time he had explained to the facility the water temp at the boiler had to be set to at least 140 degrees since their dish machine was a low temp machine and does not have a heater to warm the machine's water to be 120 degrees Fahrenheit during the final rinse cycle. On 10/17/14 at 11:46 AM an interview was conducted with the Maintenance Director. He stated he was aware that the boiler needed to be set at 140 degrees Fahrenheit in order for the kitchen's dish machine to reach 120 degrees Fahrenheit during the machine's final rinse cycle, but he was told he had to keep the boiler set at 112 degrees Fahrenheit by Administration due to	F 371		

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F 371	Continued From page 193 Life Safety codes. On 10/17/14 at 11:52 AM an interview was conducted with Dietary Aide #1. She verified her initials on the dishwasher temperature logs and that the final rinse cycle temperature was less than 120 degrees. She stated she could not recall if she had informed the DM each time the machine's final rinse cycle temperature was below 120 degrees Fahrenheit. On 10/17/14 at 12:00 PM an interview was conducted with Dietary Aide #2. She indicated the dish machine's final rinse cycle temperature was to be at least 120 degrees Fahrenheit. She verified her initials on the dishwasher temperature log and that she had recorded the temperatures accurately at less than 120 degrees Fahrenheit. She failed to report to the DM that the machine's final rinse cycle was not operating correctly. On 10/17/14 at 3:52 PM an interview was conducted with the Corporate District Dietary Manager. She stated she expected the dietary staff to stop the dish washing process, inform the dietary manager if the final rinse cycle temperature was not at least 120 degrees Fahrenheit until the DM was assured the temperature was back up to 120 degrees during the final rinse cycle. 2. On 10/12/14 at 11:50 AM the dry storage room was observed and revealed 2 dented cans; 66.5 ounces, of chunky light tuna on the shelf ready for use. On 10/13/14 at 4:43 PM observations of foods	F 371		

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F 371	Continued From page 194 stored in the dry storage room revealed 2 dented cans; 66.5 ounces, of chunky light tuna on the shelf ready for use. On 10/13/14 at 4:43 PM the DM was observed to pick up one of the dented cans of chunky light tuna and move it to the far right corner of a shelf where there were other dented cans setting. On 10/14/14 at 12:23 PM observations of the dry storage room revealed one dented can; 66.5 ounces, of chunky light tuna remained on the shelf ready for use. The DM confirmed the can of tuna was on the shelf ready for use. On 10/16/14 at 3:48 PM an interview was conducted with the DM. She stated she expected the dented cans to be placed on the shelf in the dry storage area to the far right corner. She further stated she was unaware the can of tuna was dented and that it was not supposed to be on the shelf in the ready for use area.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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	F 431		12/5/14

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F 431	Continued From page 195 applicable. 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. 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 observations and staff interviews the facility failed to discard a box of expired medication from 1 of 4 medication carts and ensure one Tuberculin, Purified Protein Derivative (PPD) vial was dated when opened in 1 of 1 medication storage room. The findings included: 1. Observations of the medication cart for the 400 hall on 10/15/14 at 11:00 AM revealed an opened box of Levalbuterol (an inhalation solution used in the treatment of asthma and chronic obstructive pulmonary disease) which contained 3 sealed packages with a total of 12 vials. The pharmacy label stated the medication was prescribed for Resident #74 with an expiration	F 431	1. No residents were affected by this citation. Expired medication Levalbuterol was removed from medication cart on 10/15/2014 by the licensed nurse. Undated vial of Tuberculin PPD was discarded on 10/17/2014 by the licensed nurse. 2. All residents have the potential to be affected by this citation. Observations of the medication carts observing for expired medications was completed 11/24/2014-12/4/2014. Licensed Nurses will inspect med carts for expired meds during their medication pass times. The medication room	

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F 431	Continued From page 196 date of 07/2014. Nurse #10 was interviewed when the box of expired medications were discovered on 10/15/14 at 11:00 AM and stated she was told a nurse had checked the 400 hall medication cart for expired medications yesterday. Nurse #10 confirmed the box of expired Levabuterol should have been removed from the medication cart when it expired in 07/2014. During an interview on 10/17/14 at 12:35 PM the Director of Nursing (DON) stated night shift nurses were responsible for checking the medication carts for expired medications nightly and he would have expected the Levalbuterol vials for Resident #74 to have been removed from the medication cart when they expired. 2. Observations of the medication storage refrigerator on 10/17/14 at 10:58 AM revealed one opened 1 ml (milliliter) vial of Tuberculin, PPD (used for skin test in the diagnosis of Tuberculosis) with an expiration date of 03/2016 with no date indicating when the vial had be opened. Review of the package information for Tuberculin, PPD revealed the manufacturer guidelines stated in part: "Once entered, vial should be discarded after 30 days." Nurse #4 was interviewed when the undated vial of Tuberculin, PPD was discovered on 10/17/14 at 10:58 AM and stated Tuberculin, PPD vials should be dated when opened. During an interview on 10/17/14 at 12:35 PM the DON stated nurses were expected to date	F 431	refrigerator will be checked by the Licensed nurses as they remove or add medications every shift as needed. Observation of the medication storage refrigerator for expired medications was completed 11/24/2014-12/04/2014. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses on dating vials once opened and check for and remove expired medications from medication carts 11/24/2014-12/4/2014. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of the medication carts for expired medications 5 times a week for 1 month, 3 times a week for 2 month, 2 times a week for 2 month and 1 time a week for 1 months and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of the medication storage refrigerator for expired medications 5 times a week for 1 month, 3 times a week for 2 month, 2 times a week for 2 month and 1 time a week for 1 months and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement	

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F 431	Continued From page 197 Tuberculin, PPD vials when opened and discard the vials 30 days after the opened date.	F 431	Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	
F 441 SS=E	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 (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	F 441		12/5/14

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F 441	Continued From page 198 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 observations and laundry provider consultant and staff interviews the facility failed to monitor washing machine water temperature's to assure proper disinfection of facility linens and resident clothing. The findings include: Review of the facility kitchen temperatures from 01/01/14 thru 10/11/14 revealed the highest kitchen water temperature to be 150 degrees Fahrenheit (F) and the lowest at 139 degrees F. During an environmental tour of the facility with the Maintenance Director on 10/15/14 at 10:02 AM the laundry room was observed to have two industrial size washers and dryers. There was no temperature gauge observed on either washing machine. An interview was conducted on 10/15/14 at 10:15 AM with the Maintenance Director. He stated he checked the water temperature going to the washing machines in the mornings but did not record them. He reported the washing machine temperature should be the same as kitchen water temperature because they were from the same mixing valve. He further stated he did not check the washing machine temperature throughout the day to see if they were maintaining temperature. An interview was conducted on 10/15/14 at 3:14 PM with Housekeeping Aide #1. She stated she	F 441	1. No residents were affected by this citation. The Maintenance Director increased the temperature to the boiler on 10/15/2014. Combustion and Control Solutions INC serviced the boiler on 10/28/2014. A gauge for measuring temperature of water for washer will be placed. 2. All residents have the potential to be affected by this citation. 3. The Maintenance Director was in serviced by the Executive Director on maintaining the water temperature 135-140 degrees that feeds to the washers 11/21/2014. Laundry Services was in serviced on 11/25/2014 - 11/26/2014 for monitoring the temperature of washers and should temperature fall below 135 degrees put washer out of service and notify Maintenance Director by the Executive Director. Maintenance Director and/or Executive Director will perform Quality Improvement monitoring of water temperature to kitchen/washers 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2	

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F 441	Continued From page 199 had worked at the facility 6 months and had never checked the water temperature of the washing machines. She stated she had no idea if the water was hot enough to disinfect linens and resident clothing. An interview was conducted on 10/16/14 at 8:25 AM with Housekeeping Aide #2. She reported she had worked in the laundry room at the facility for 7 years and had never checked the water temperature of the washing machines. She stated she knew the water was hot by placing her hand on the glass door of the washing machine during the wash cycle. She further stated she did not know what parts per million of bleach solution was used during the wash. The contracted laundry service regulated the detergent, bleach and softener going into the machine and all she had to do was press which wash she wanted to use on the control box that was located on the upper left hand corner of both washing machines. An interview was conducted on 10/16/14 at 2:45 PM with the Director of Nursing (DON). He stated he was not aware daily washing machine temperatures were not being recorded. He stated his expectation would be for the water temperature in the washing machines to be checked and recorded daily. An interview was conducted on 10/17/14 at 10:41 AM with the facility District Manager of Housekeeping. He stated the facility did not check water temperature of the washing machines because they were fed by the same water line the kitchen was on and they monitored the kitchen water temperatures daily. He further stated the Center for Disease Control (CDC) recommended water temperature for washing linens and resident clothes to be 160 degrees and that was what the facility kitchen water temperatures normally were.	F 441	times a week for 4 weeks and 1 time a week for 4 weeks and/or substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Maintenance Director for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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F 441	Continued From page 200 A telephone interview was conducted on 10/17/14 at 10:41 AM with the Consultant for laundry services. He stated the company he worked for manages the laundry equipment for the facility. He stated the facilities washing machines were hot water washes and there was not a temperature gauge on either washing machine. He reported the only way they could check the temperature of the water correctly was inside the drum. He stated the recommended temperature for the washing machine was 145 degrees and the highest bleach solution they used was 75 parts per million.	F 441		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to communicate results of a physician ordered laboratory test to the physician to review for 1 of 7 residents reviewed for unnecessary medication use (Resident #57). The findings included: Review of the medical record revealed Resident #57 was admitted on 06/25/12 with diagnoses including hypercholesterolemia. Review of physician's orders revealed an order dated 04/09/14 for a fasting lipid profile (measures different types of cholesterol in the blood) per Pharmacy recommendation with a	F 505	1. Resident #57 was not injured by this citation. Resident #57 was assessed by the physician 11/18/2014. 2. All residents have the potential to be affected by this citation. An audit of current residents with labs drawn to see if notification to physician occurred 11/24/2014-12/4/2014 by the Director of Clinical Services and/or Nursing Supervisor. 3. The Director of Clinical Service□s in serviced licensed nurses on notifying physician of lab results 11/24/2014-12/4/2014.	12/5/14

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F 505	Continued From page 201 recheck annually. Review of current physician's orders for October 2014 revealed Resident #57 was prescribed Pravachol (used to lower cholesterol and triglycerides in the blood) 20 mg (milligrams) by mouth daily. Review of Resident #57's laboratory test results revealed no results for the fasting lipid profile ordered by the physician on 04/09/14. An interview with Nurse #10 on 10/16/14 at 1:00 PM revealed routine laboratory tests were obtained weekly on Monday and Wednesday and the laboratory sends the results back to the facility through the fax machine. Nurse #10 stated nurses called or faxed abnormal laboratory test results to the physician immediately and placed the results in the physician's box. If the test results were within normal limits the nurse would place the results in the physician's box to review on their next visit. During an interview on 10/15/14 at 3:30 PM the Director of Nursing (DON) reviewed Resident #57's medical record and confirmed there were no results for the fasting lipid profile ordered on 04/09/14 and could not explain why the results were not in the medical record. During a follow up interview on 10/15/14 at 4:30 PM the DON reported he had contacted the hospital laboratory and they had faxed him the results Resident #57's fasting lipid profile which had been drawn on 04/13/14. The DON stated the facility had implemented a new audit system for laboratory test results in July 2014. The audit system followed all laboratory orders from when	F 505	The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of physician notification of labs timely 5 times a week for 1 month, 3 times a week for 2 months, 2 times a week for 2 months and 1 time a week for 1 month and/or until substantial compliance is obtained. 4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services for six 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, Assistant Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse.	

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F 505	Continued From page 202	F 505		

they were ordered until the results were reviewed by the physician and placed on the medical record.

A telephone interview was conducted with the Pharmacist on 10/21/14 at 11:42 AM. The Pharmacist reviewed his documentation during the interview and stated he had recommended a fasting lipid panel for Resident #57 during his monthly medication review on 03/19/14 because the last lipid profile on her medical record was dated 03/19/13. The Pharmacist stated he sent repeat recommendations to the facility for a lipid profile on 06/23/14 and 09/23/14. The interview further revealed the Pharmacist mailed a printed copy of his recommendations to the facility after each monthly visit.

During an interview on 10/21/14 at 9:46 AM the Physician stated he typically monitored a lipid profile once or twice a year for residents prescribed a cholesterol lowering medication. The Physician further stated he expected laboratory tests to be collected as ordered and the results available for review by him timely. The Physician explained the lipid profile was not a high priority laboratory test and he did not follow up on it himself. The interview further revealed he made rounds at the facility every Tuesday and Thursday and the Medical Records Coordinator compiled the orders, consultations, and recommendations for him to sign.

An interview with the DON on 10/21/14 at 11:30 AM revealed the Pharmacist mailed a printed copy of his recommendations to the facility after each monthly visit. The DON stated he reviewed the recommendations against laboratory tests that may have already been completed for a

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F 505	Continued From page 203 resident and then made a copy of the recommendations to make sure necessary laboratory test were ordered and completed. The DON did not recall seeing the repeat recommendations for lipid panels for Resident #57 and was not able to locate his copies of the Pharmacist's repeat recommendations for lipid panels dated 06/23/14 and 09/23/14. The DON further stated the current laboratory audit system would not catch a repeat recommendation that had not been addressed.	F 505		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		12/5/14

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F 520	Continued From page 204 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff and resident interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in September of 2013 and November of 2013. This was for six recited deficiencies which were originally cited in August of 2013 on a recertification survey and for follow up and complaint surveys in September of 2013 and November 2013 and again on the current recertification and complaint survey. The deficiencies were in the areas of choices, comprehensive resident assessments, resident assessment every 90 days, activities of daily living, supervision to prevent accidents, and significant medication errors. The continued failure of the facility during three federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1a. F 242: Choices: Based on resident, family and staff interviews, and record review, the facility failed to provide 1 of 5 sampled residents with the number of showers she preferred per week. (Resident #100). The facility was originally cited for F 242 for failing to provide residents with the amount or type of baths/showers they wanted each week for 4 of 6 residents during the August 16, 2013	F 520	1. No resident was harmed related to this citation. Mountain Area Health Education Center will provide directed in service to the Quality Assurance Performance Improvement Committee members on 12/1/2014. 2, The ED/DCS have been re-educated on the regulation F 520 and the Facility□s Policy and Procedure for Quality Assurance and Performance Improvement by the Regional Director of Clinical Services and The Regional Director of Operations on 11/20/2014. The RDCS/RDO has re-educated the Interdisciplinary Team members on regulation F520 and the Facility□s Policy and Procedure for Quality Assurance Performance Improvement on 11/20/2014. Mountain Area Health Education Center will provide directed in service to the Quality Assurance Performance Improvement Committee members on 12/1/2014. The Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) interviewed residents and/or their responsible parties for shower preferences and get up times 11/18/2014-11/21/2014. An audit of current resident□s last two assessments, Minimum Data Set, was	

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	345433	A. BUILDING _____ B. WING _____	C 10/28/2014

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F 520	Continued From page 205 recertification survey. On the current recertification and complaint survey the facility was again cited for failing to provide the number of showers a resident preferred each week. b. F 272: Comprehensive Assessments: Based on observations, record reviews and staff interviews, the facility failed to comprehensively assess 10 of 28 sampled residents identifying how their condition affected each resident's function and quality of life. (Residents #1, #11, #34, #58, #60, #61, #69, #81, #91, and #100). The facility was originally cited for F 272 for failing to assess 3 of 27 residents for skin tears and bruising, dental problems, and pressure ulcers on the recertification survey of August 16, 2013. On the current recertification and complaint survey the facility also failed to comprehensively assess residents for activities of daily living, urinary Incontinence/indwelling urinary catheter, nutrition, psychotropic drug use, behaviors, mood, pressure ulcers, pain, restraint use, cognition, falls, and vision. c. F 276 Resident Assessments Every 90 Days: Based on record review and staff interview, the facility failed to complete quarterly assessments within the required time frame for 2 of 16 residents sampled for timeliness of quarterly assessments. (Residents #61 and #100). The facility originally was cited for F 276 for failing to complete quarterly assessments within the required time frame for 1 of 27 residents on the recertification survey of August 16, 2013. The same deficient practice was found on the current recertification and complaint survey. d. F 312 Activities of Daily Living: Based on observations, record reviews, and staff and	F 520	completed 11/10/2014-12/04/2014 by the Regional Case Mix Coordinator. Observation of residents toe nails was completed 11/20/2014-11/24/2014 by the licensed nurse to identify nails that required care. An audit of residents who require turning every two hours care plans was completed 11/20/2014-11/28/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Minimum Data Set Nurse, Activities). Observations of peri care were completed 11/19/2014-11/28/2014 by the Director of Clinical Services and/or Nursing Supervisor. Observations for medications at the bedside was completed by the Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) 11/17/2014-11/19/2014. Current residents care plans and kardex were reviewed and updated if needed 11/24/2014-12/4/2014 by the Interdisciplinary Team (Director of Clinical Services and/or Nursing Supervisor, Dietary Manager, Social Services, Minimum Data Set Nurse, Activities). An audit of the last 30 days of falls and/or investigations was completed by the director of nursing and/or nursing supervisor 11/24/2014-12/04/2014.Current residents receiving Antibiotics orders were verified as Transcribed correctly to the medication administration record 11/21/2014-12/4/2014 by the Director of	

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F 520	Continued From page 206 resident interviews the facility failed to provide repositioning every 2 hours, showers and getting out of bed in the morning as residents requested, bed baths between showers, and trimming of toenails for 4 of 11 residents reviewed for activities of daily living. (Residents #60, #67, #89, and #91). The facility originally was cited for F 312 for long and dirty fingernails for 2 of 4 residents and failure to provide showers for 1 of 4 resident on the recertification survey of August 16, 2013. The facility was also cited for F 312 for lack of oral care for 1 of 3 residents on the follow up and complaint survey of September 20, 2013. Again, the facility was cited for F 312 for failure to bathe 1 of 4 residents on the follow up and complaint investigation of November 1, 2013. On the current recertification and complaint survey deficient practice was found with repositioning a resident every 2 hours, providing shower frequency as requested, requiring a resident to wait in the morning to get out of bed, provide bed baths between showers, and failure to trim toenails. e. F 323 Supervision to Prevent Accidents: Based on observations, record reviews, staff interviews and family interview, the facility failed to investigate the circumstances surrounding falls and implement planned interventions to prevent reoccurring falls for 2 of 8 sampled residents (Residents #94 and #100) who had histories of falls; and failed to investigate and identify how prescription, discontinued and currently prescribed inhalers were repeatedly found at 1 of 8 resident's bedside (Resident #58) who were sampled for medication review.	F 520	Clinical Services and/or Nursing Supervisor. 3. Director of Clinical Services and/or Nursing Supervisor will perform audit of residents receiving showers and/or bed baths for honoring of preferences 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 1 month and 1 time a week for 1 month and/or substantial compliance is obtained. The Director of Clinical Services will perform Quality Improvement monitoring of the Minimum Data Set/Care Area Assessments 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks and/or until substantial compliance is obtained. The Director of Clinical Services will perform Quality Improvement monitoring of the completion of the quarterly Minimum Data Set Assessments 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks and/or until substantial compliance is obtained. The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement monitoring of 2 certified Nurse Assistant providing peri care each shift 5 times a week for 1 month, 3 times a week for 1e month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of residents requiring frequent repositioning 5 times a week for 1 month, 3 times a week for 1	

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F 520	Continued From page 207 The facility was originally citied on the original recertification survey of August 16, 2013 for F 323 for failure to provide treatment of skin tears resulting in cellulitis for 1 of 4 residents. The facility was also citied on the follow up and complaint survey of September 20, 2013 for F 323 for failure to prevent injury which required amputation while being pushed in a wheelchair with no foot rests and wearing cloth shoes for 1 of 3 residents. On the current recertification and complaint survey deficient practice was found with failing to investigate why a resident continued to fall, implement planned interventions to prevent falls, and to investigate and identify how prescription and discontinued inhalers were repeatedly found at a resident's bedside. f. F 333 Significant Medication Error: Based on record review and staff interviews, the facility failed to transcribe and administer an antibiotic per physician orders for 1 of 7 residents sampled for medication review. (Resident #61). The facility was cited on the follow up and complaint survey of November 1, 2013 for F 333 for failure to prevent a significant medication error by not administering four doses of eye drops for a diagnosis of glaucoma for 1 of 4 residents. On the current recertification and complaint survey, the facility failed to transcribe and administer an antibiotic per physician's orders. An interview was conducted with the Administrator and Director of Nursing (DON) on 10/21/14 at 4:43 PM. The Administrator stated the Quality Assessment and Assurance Committee (QAA) met monthly. The DON stated he came to the facility in July of 2014 and had put	F 520	month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. Director of Clinical Services and/or Nursing Supervisor will perform audit of residents receiving showers and/or bed baths for honoring of preferences 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 1 month and 1 time a week for 1 month and/or substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of residents requiring frequent repositioning 5 times a week for 1 month, 3 times a week for 1 month, 2 times a week for 2 month and 1 time a week for 2 months and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of 10 residents toe nails 3 times a week for eight weeks, 2 times a week for eight weeks, 1 times a week for eight weeks and/or until substantial compliance is obtained. The Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Activities, Medical Records) will perform Quality Improvement monitoring of 10 resident rooms for medications at the bedside 5 times a week for 8 weeks, 3 times a week for 8 weeks, 2 times a week for 4 weeks, 1 time a week for 4 weeks and/or substantial compliance obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality	

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F 520	Continued From page 208 systems in place to address showers provided as requested and to ensure laboratory tests were completed as ordered by the physician and the physician received the results. Other programs such as department heads completing mock surveys daily on assigned residents had been instituted. The DON stated these were ongoing processes and there was still a lot of work to be done. A continued interview was conducted with the Regional Director of Operations (RDO) on 10/22/14 at 3:10 PM. He acknowledged the facility had experienced frequent turnover in management staff since the survey in December of 2013. The RDO stated the Regional Director of Clinical Services had maintained a presence in the facility to assist with transition to oversee issues of concern were followed. The RDO stated he does attend the QAA meeting at the facility as frequently as possible. He stated the facility had maintained focus on activities of daily living, choices, and addressing grievances. He added there were still areas that required focus on improvement.	F 520	Improvement monitoring of investigations and fall care plans interventions have been implemented 3 times a week for 8 weeks, 2 times a week for 8 weeks, 1 time a week for 8 weeks and/or until substantial compliance is obtained. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of physician orders to ensure they were transcribed accurately to the medication administration record 5 times a week for 1 month, 3 times a week for 2 month, 2 times a week for 2 month and 1 time a week for 1 months and/or until substantial compliance is obtained. The RVPO and/or the RDCS will conduct QI monitoring of the facility□s QAPI process by attending, to ensure that issues identified are handled appropriately using an action plan. The RVPO, RDCS and/or the Regional Case Mix Coordinator will attend QAPI 1 x monthly for 3 months. 4. The DCS/Nurse Manager will report results to the QAPI committee monthly x6 months for continued substantial compliance and/or revision. When substantial compliance is obtained the QAPI team will continue to review and discuss citations cited during subsequent meetings to maintain compliance and identify new or reoccurring issues. The RVPO, RDCS and/or Regional Case Mix Coordinator will report results of QI monitoring to the QAPI Committee monthly x3 months for continued substantial compliance and/or revision.	