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 _____	02/08/2019

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
E 000	Initial Comments An unannounced recertification survey was conducted on 2/05/19 - 02/08/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID DDIG11.	E 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		3/8/19

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

Electronically Signed | 02/28/2019

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F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to repair broken and splintered entrance doors to resident rooms on 2 of 4 hallways (Resident Rooms #209, #213, #215, #304, #306 and #314). The findings included: 1. The following observations were related to the facility's failure to repair broken entrance doors to resident rooms with sharp splintered edges at the lower portion of the doors: a. Observation of Room #215 on 02/05/19 at 2:42 PM revealed the entrance door was broken with sharp splintered edges approximately 10 inches long at the lower portion of the door. Subsequent observations made on 02/06/19 at 2:58 PM and 02/07/19 at 11:47 AM revealed the door remained in disrepair. b. Observation of Room #213 on 02/05/19 at 2:56 PM revealed the entrance door was broken with sharp splintered edges due to ripped lamination at the lower portion of the door. Subsequent observations made on 02/06/19 at 10:33 AM and 02/07/19 at 11:45 AM revealed the door remained	F 584	Door to rooms 209, 213, 215, 304, 306, and 314 were fixed on 2-21-2019. Maintenance Director completed a %100 audit of all doors on 2-14-2019. All doors with sharp and rough edges; splintered edges and ripped laminate on doors will be repaired by 3-8-2019 Maintenance Director was educated by administrator on 2-14-2019 regarding the importance of preventative maintenance to ensure residents are free of hazards. Maintenance to round weekly and as needed to maintain doors. Door checks will be added to the mock survey round sheet on 2-21-2018. Maintenance Director educated department heads who complete the mock surveys on what to review daily pertaining to the doors. This education was done on 2-14-2019. Mock surveyors are department heads that include Medical records, Central Supply, Activity staff, Social Services, Admissions and Administrator in Training. Findings will be kept in the administrators office. Administrator to complete Quality	

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F 584	Continued From page 2 in disrepair. c. Observation of Room #304 on 02/05/19 at 3:16 PM revealed the entrance door was broken with several splintered sharp edges due to ripped lamination on the bottom 2 feet of the door. Subsequent observations made on 02/06/19 at 3:05 PM revealed the door remained in disrepair. d. Observation of Room #209 on 02/05/19 at 4:21 PM revealed the entrance door was broken with sharp splintered edges due to ripped lamination at the lower right portion of the door. Subsequent observations made on 02/06/19 at 9:51 AM and 02/07/19 at 11:49 AM revealed the door remained in disrepair. e. Observation of Room #314 on 02/07/19 at 12:08 PM revealed the entrance door was broken with sharp splintered edges approximately 10 inches long due to ripped lamination at the lower portion of the door. f. Observation of Room #306 on 02/07/19 at 12:11 PM revealed the entrance door was broken with sharp splintered edges due to ripped lamination at the lower portion of the door. During an environmental tour conducted on 02/07/19 at 1:21 PM with the Maintenance Manager (MM) and the Administrator, the above mentioned entrance doors with sharp edges for Room #209, #213, #215, #304, #306, and #314 were observed and remained in disrepair. During an interview conducted on 02/07/19 at 1:37 PM, the MM acknowledged that the sharp edges at several entrance doors were safety hazards and stated it was his oversight due to	F 584	Improvement Monitoring (QIM) for doors. Quality Improvement Monitoring, (QIM) to include sharp and rough edges, splintered edges and ripped laminate.. Rounds will be made Monday thru Friday for 4 weeks, then 1x weekly for 3 months. QIM results will be brought to QAPI meeting for 4 months. The daily round sheets will be kept in the Administrators office. All corrections will be made by 3-8-2019. Maintenance Director is responsible for the plan. The Maintenance Director will present the plan to the QAPI committee on 3-7-2019. The administrator is responsible for the implementation of the plan. The committed consists of the Administrator, DON, ADON, Medical Director, MDS, Medical Records, CTRS, Social Worker and one director care giver. QIM schedule is based on findings.	

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F 584	Continued From page 3 recent overwhelming workloads. According to the MM, he was the only maintenance staff in the facility. He used to have one maintenance assistant worked under him who quit about 2 weeks ago. The MM stated on a regular basis, he did walk a through of the facility at least once per week to identify maintenance needs. Otherwise, he depended on staff to report maintenance concerns via verbal reports or work orders. The MM added maintenance work was prioritized with safety concerns being addressed first, equipment issues addressed second and cosmetic issues addressed third. During an interview conducted on 02/07/19 at 2:12 PM, the Administrator stated the maintenance department was currently interviewing applicants to fill in the empty vacancy. He attributed the doors with sharp edges as an oversight in the part of MM. It was his expectation for the facility to remain free of safety hazards.	F 584		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow a physician order to obtain daily weights for 1 of 2 residents reviewed for nutritional status (Resident #67). The findings included:	F 658	Resident #67 is no longer on daily weights. MDS completed a 100% audit on 2-22-2019 to ensure all residents on daily weights are identified and care planned	3/8/19

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F 658	Continued From page 4 Resident #67 was originally admitted to the facility on 01/02/15. The quarterly Minimum Data Set (MDS) dated 09/11/18 revealed Resident #67 had congestive heart failure (CHF) and was taking a daily diuretic. The MDS also revealed Resident #67 weighed 191 pounds with no significant weight loss or gain in the past 6 months. Record review of the Team Health Provider Visit Form dated 11/27/18 revealed Resident #67 was refusing a prescribed diuretic (taken to reduce extra fluid in the body). A request was made from nursing staff on 11/27/18 to discontinue the medication for Resident #67 and the physician responded "Ok to stop. Be sure he's weighed daily." Record review of physician's orders dated 11/27/18 revealed Resident #67 was to be weighed daily at 6:00AM. No parameters for notifying the physician for weight loss or weight gain was listed. Record review of the Medication Administration Record (MAR) for November 2018 revealed no weight or refusals of weight to be taken was documented on 11/29/18 for Resident #67. Record review of the MAR for December 2018 revealed no weights or refusals of weights to be taken was documented on the following dates: 12/03/18, 12/07/18, 12/08/18, 12/22/18 and 12/24/18 for Resident #67. Resident #67 was discharged from the facility to the hospital on 01/01/19 and returned to the facility on 01/04/19 with diagnoses including CHF exacerbation, possible pneumonia and urinary	F 658	accordingly. Currently there is 1 resident on daily weights. Weight (s) to be obtained between 5am and 7am daily. Physician to be notified if >5lbs. in 24 hour period. Daily weights will be monitored by DON and or designee Monday thru Friday. 100 hall nurse will monitor Saturday and Sunday. Quality Improvement Monitoring (QIM) for all residents will be maintained by the DON in her office. This was completed by 3-8-2019. All nursing staff will be re-educated by the DON and or designee regarding physician orders pertaining to daily weights by 3-8-2019. Physician orders will be reviewed in morning meeting. Care plans and kardex will be updated at this time. All daily weights will be documented on between 5 am and 7 am daily. Don will monitor daily for 4 weeks then weekly for 3 months to ensure compliance. Outcomes will be reported to the QAPI committee monthly. Director of Nursing is responsible for the plan. The DON will present the plan to the QAPI committee on 3-7-2019. The administrator is responsible for the implementation of the plan. The committed consists of the Administrator, DON, ADON, Medical Director, MDS, Medical Records, CTRS, Social Worker and one director care giver. QIM schedule is based on findings.	

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F 658	Continued From page 5 tract infection (UTI) among others. On 02/08/19 at 12:10PM, assistance from the Director of Nursing (DON) was requested to find the missing weights from November and December 2018. The DON reviewed the weight sheets, front and back of the MAR for November and December of 2018 and nurses notes for November and December 2018. The DON was unable to find the daily weights missing or documentation of the refusal of Resident #67 to be weighed for 11/29/18/ 12/03/18, 12/07/18, 12/08/18, 12/22/18 and 12/24/18. During an interview on 02/08/19 at 12:27 PM the DON stated that daily weights were supposed to be documented on the MAR and should also be transcribed over to the weight sheet. The DON also stated the MAR was reviewed daily by the desk nurse or the Assistant Director of Nursing (ADON) and this error should have been caught. The DON stated her expectation was for physician orders to be followed. During an interview on 02/08/19 at 1:34 PM with Nurse Supervisor #1 she stated if there was a doctor's order present that had not been discontinued you were supposed to follow it. During an interview on 02/08/19 at 1:40PM with Nurse Supervisor #2 she stated staff should follow physician's orders for residents and call the physician to clarify the order if there were any questions.	F 658		