		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DA	ITE SURVEY MPLETED
		345433	B. WING			C)1/29/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLAY CO	JNTY CARE CENTER			86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	0		
F 157 SS=D	Nursing Home Licens Section provided the Statement of Deficient included citation F-30 483.10(b)(11) NOTIF (INJURY/DECLINE/R A facility must immed consult with the resid known, notify the resi or an interested famil accident involving the injury and has the pot intervention; a signific physical, mental, or p deterioration in health status in either life the clinical complications significantly (i.e., a ne existing form of treath	facility with an amended icies on 02/20/15, which 9. Event ID # 92L311. Y OF CHANGES 200M, ETC) iately inform the resident; ent's physician; and if dent's legal representative y member when there is an e resident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a n, mental, or psychosocial reatening conditions or); a need to alter treatment eed to discontinue an nent due to adverse commence a new form of ion to transfer or discharge	F 15	7		2/17/15
	and, if known, the res or interested family m change in room or roo specified in §483.15(resident rights under	promptly notify the resident ident's legal representative nember when there is a commate assignment as (e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of				
		rd and periodically update number of the resident's				
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					02/13/2015

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 02/23/2015

OLITILI		MEDICAID SERVICES					O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	` '	E SURVEY PLETED
	CONNECTION	IDENTIFICATION NOWDER.	A. BUILDII	NG			
		0.45400					С
		345433	B. WING			01	/29/2015
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CLAY CO	UNTY CARE CENTER		86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETIO
F 157	Continued From page	e 1	F	157			
		or interested family member.					
		T is not met as evidenced					
	by:						
		ons, medical record review			A. Resident #4 no longer resides at t	he	
	and staff interviews t	he facility failed to promptly			facility.		
		of a change in condition for 1					
	of 3 sampled residen	its.			B. All residents have the potential to b	ре	
-	(Resident #4)				affected by this citation		
	The finalization is also de	4.			A review of current residents was		
	The findings included	d:			completed by the Director of Clinical		
	Posidont #4 was adn			Services, Assistant Director of Clinica			
		nitted to the facility 04/30/12 n included: dysphagia,			Services and Nurse Manager on 2/12 to ensure all residents were stable an		
	dementia without ber				experiencing a change in condition. I		
		of physician orders in the			issues were identified .	NO	
		sident #4 on 01/28/15					
	revealed no orders for				C. The Director of Clinical Services/N	urse	
		,,,			Supervisor in-serviced licensed nursi		
	On 01/28/15 at 3:15	PM Resident #4 was			staff on completing the Situation	-	
	observed in bed, on l	her back with a pulse			Background Request (SBAR)form wit	h a	
	-	hich readily assesses			change in resident condition to includ	е	
		nd pulse) on her finger.			notification of the physician and		
		ed to be sleeping and did not			responsible party/resident of the char		
		n to. The reading on the			in condition on 2/4/15 thru 2/15/15. T	he	
		ated an oxygen saturation of			Director of Clinical Services/Nurse		
		aturation a normal reading			Supervisor inserviced Certified Nursin	•	
		nt #4 was not wearing f the observation. NA #3			Assistants on notifing the licensed nu of an observed change in the residen		
		3:17 PM and reported she			using the Interact tool, Stop and Wate		
		sident #4 and that "she didn't			2/4/15 thru 2/15/15. New licensed nu		
		y does." NA #3 removed the			employee will be educated on complete		
		ger of Resident #4 and			of the SBAR form with resident change		
		aware of the low oxygen			condition to include notification of the		
	saturation and was g	oing to call the physician.			physician, responsible party/resident		
					during orientation by the Director of		
		PM Nurse #1 (on duty 7:00			Clinical Services/Nurse Supervisor.	Vew	
	AM-3:00 PM on 01/2	o/15) was observed			Certified Nursing Assistants will be		

Facility ID: 923105

If continuation sheet Page 2 of 15

			0.00			38-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURV COMPLETE	
			A. BUILDING	3	с	
		345433	B. WING			045
	ROVIDER OR SUPPLIER	040400		STREET ADDRESS, CITY, STATE, ZIP COD	01/29/2 ⊨	015
	NOVIDEIN ON SOFT EIEN		86 VALLEY HIDEAWAY DRIVE			
CLAY CO	JNTY CARE CENTER			HAYESVILLE, NC 28904		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE CO	MPLETIO DATE
F 157	Continued From page	e 2	F 15	57		
		en concentrator to the room		educated on notifying the lice	nsed nurse	
	of Resident #4. On 0			of observed changes in reside		
		erved in bed with a nasal		using the Interact tool, Stop a		
	cannula in place with	oxygen being administered		during orientation by the Dire		
	-	On 01/28/15 at 4:45 PM		Clinical Services/Nurse Supe		
	Nurse #2 (on duty 3:0	00 PM-11:00 PM on		DCS/Nurse Supervisor will pe		
	01/28/15) reported w	hen oxygen saturation levels		Quality Improvement Monitor	ng of 10	
	had earlier been che	cked on Resident #4 two		residents medical records for	notification	
	separate readings we	ere obtained; one at 62%		of change in condition to phys	ician and	
	and one at 75%. Nu	rse #2 stated the low oxygen		responsible party/resident 5 ti	mes a week	
		issue for Resident #4 but,		for 8 weeks, then 3 times a w		
		n was being administered via		weeks then 2 times a week for		
		liters per minute. Nurse #2		and/or until substantial compl	ance is	
		Resident #4 was not feeling		obtained.		
	well and that she wor					
		01/28/15 at 5:35 PM Nurse		D. The results of the Quality I		
		ked Resident #4's oxygen		Monitoring will be reported to	•	
		obtained a reading of 71%		Assessment Performance Im		
		flow rate from 2 liters per		Committee by the Director of		
	-	minute. On 01/28/15 at 6:08		Services/Nurse Supervisor un		
		observed in bed with oxygen		substantial compliance is obta		
		r minute. A pulse oximeter		Quality assessment Performa		
		finger of Resident #4 with a turation reading of 80%.		Improvement Committee mer consist of but not limited to th		
				Director, DCS, Assistant DCS		
	Nurses documentatio	on in the medical record of		Care Nurse, Medical Director		
	Resident #4 indicated			Service, Maintenance Director		
		:00 PM This writer informed		Minimum Data Assessment N		
		vell and is in bed. Vital signs				
		9, oxygen saturation at 62%.				
	This writer informed					
		then started oxygen at 3				
		uration up to 81% at 7:30				
		ion at 91% on 4 liters per				
		nula. Will continue to				
	monitor					
	01/28/15 11:00 PM	/ital signs: Temperature				
	i la					
	99.7, pulse 108, 81%	saturation on 3 liters per				

If continuation sheet Page 3 of 15

	-	D HUMAN SERVICES				FORM): 02/23/2015 1 APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		345433	B. WING		_	(01/:	C 29/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
				86 VALLEY HIDEAWAY DR	IVE		
	JNTY CARE CENTER			HAYESVILLE, NC 28904	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	01/29/15 5:00 AM Re- respirations at times. 2 liters per minute via On 01/29/15 at 9:45 A observed in a geri cha- elevated. Resident # and appeared to be c 01/29/15 at 9:50 AM I the start of her shift of had checked the oxyg #4 twice and both tim 90s. Nurse #3 was of oxygen saturation of I the interview and the pulse oximeter was 8 was going to call the p and let him know her On 01/29/15 at 9:50 A reporting the concern conversation to the pI noting the resident ha saturations on 01/28/ saturation was curren obtained from the phy X-ray and to begin ox Immediately after the physician oxygen was Resident #4 via a nas minute. On 01/29/15 at 2:45 F Resident #4 was inter he had not been calle Resident #4 until 01/2 nurses notes in the m indicating low oxygen	esident resting in bed, rapid Oxygen saturation 94% on nasal cannula. AM Resident #4 was air with the back of the chair 4 was not wearing oxygen omfortably resting. On Nurse #3 stated that since n 01/29/15 at 7:00 AM she gen saturation of Resident es the levels were in the bserved checking the Resident #4 at the time of reading displayed on the 6%. Nurse #3 stated she ohysician of Resident #4 status. AM Nurse #3 was overheard via a telephone hysician of Resident #4 id experienced low oxygen 15 and that the oxygen tly at 86%. Orders were visician for lab work, a chest ygen at 2 liters per minute.	F 15	7			

Facility ID: 923105

If continuation sheet Page 4 of 15

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/23/2015 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345433	B. WING				C / 29/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLAY CO	UNTY CARE CENTER				86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	oxygen saturation wa because 62% is such have had staff warm to recheck the reading w her ear lobe for accur specific oxygen saturation 60s-80s had not been conversation with Nur called at 9:50 AM. The Resident #4 was not a saturation was of con- results of the chest X- the situation. On 01/29/15 at 3:15 F beginning of her shift told Resident #4 had oxygen saturation. N been told the oxygen in the 60s-80s on 01/2 relayed that also to the called at 9:50 AM. On 01/29/15 at 4:23 F first shift on 01/28/15) end of her shift on 01/2 oxygen saturation dro Nurse #1 stated Nurs PM-11:00 PM on 01/2 the physician of Resid concern as well as ob oxygen. Attempts were made 01/29/15 but Nurse #2 interview. On 01/29/1 Director of Clinical Set	mediately if the resident's s at 62%. The MD stated a low reading he would the resident's hands and/or with the pulse oximeter on acy. The MD stated the ation readings in the reported in the rse #3 when he was the MD stated that because routinely on oxygen the low cern and he was awaiting tray and lab work to assess PM Nurse #3 stated at the on 01/29/15 she had been been on oxygen due to low urse #3 stated if she had saturation levels had been 28/15 she would have e physician when he was PM Nurse #1 (that worked o stated that it was at the /28/15 that staff noted the opped on Resident #4. e #2 (that worked 3:00 28/15) told her she would call	F	157			

If continuation sheet Page 5 of 15

				MB NO. 0938-039 (X3) DATE SURVEY	
CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		-		С	
	345433	B. WING		01/29/2015	
ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
JNTY CARE CENTER					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG			
Continued From page	• 5	F 157			
nursing report sheets addressing Resident noted the physician o notified of the low oxy morning of 01/29/15. physician should have when oxygen saturatio 01/28/15. The DCS s with Nurse #2 to inquist stated she did not cal low oxygen saturation busy managing the ca during her shift on 01 there were other nurse during the 3:00 PM-1 been made aware of assisted Nurse #2 to oxygen saturation to 483.20(k)(3)(ii) SERV PERSONS/PER CAR The services provided	from 01/28/15-01/29/15 #4. The DCS stated he f Resident #4 had not been rgen saturation until the The DCS stated the e been immediately called on was noted at 62% on stated he had been in touch ire about this and Nurse #2 I the physician to report the b because she had been so are of residents on the unit /28/15. The DCS stated es present on 01/28/15 1:00 PM shift and if they had the concern they could have report the concern with low the physician of Resident #4. /ICES BY QUALIFIED RE PLAN d or arranged by the facility qualified persons in	F 282		2/17/15	
by: Based on observatio interviews, the facility	n, record review and staff failed to feed a resident		A. Resident #2 was not injured as a res of this citation	ult	
feeding plan that had modified barium swal	been developed following a low study for 1 of 1		have the potential to be affected by this citation. An audit of current resident's	ia	
			medical records to identify		
	PF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER JNTY CARE CENTER SUMMARY ST, (EACH DEFICIENC' REGULATORY OR I Resident #4 as well a nursing report sheets addressing Resident i noted the physician o notified of the low oxy morning of 01/29/15. physician should have when oxygen saturati 01/28/15. The DCS s with Nurse #2 to inqu stated she did not cal low oxygen saturation busy managing the ca during her shift on 01. there were other nurs during the 3:00 PM-1 been made aware of assisted Nurse #2 to oxygen saturation to 1483.20(k)(3)(ii) SERV PERSONS/PER CAR The services provided must be provided by a accordance with each care. This REQUIREMENT by: Based on observatio interviews, the facility according to her most feeding plan that had modified barium swal	PEDEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345433 ROVIDER OR SUPPLIER JINTY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Resident #4 as well as 24 hour shift to shift nursing report sheets from 01/28/15-01/29/15 addressing Resident #4. The DCS stated he noted the physician of Resident #4 had not been notified of the low oxygen saturation until the morning of 01/29/15. The DCS stated the physician should have been immediately called when oxygen saturation was noted at 62% on 01/28/15. The DCS stated he had been in touch with Nurse #2 to inquire about this and Nurse #2 stated she did not call the physician to report the low oxygen saturation because she had been so busy managing the care of residents on the unit during her shift on 01/28/15. The DCS stated there were other nurses present on 01/28/15 during the 3:00 PM-11:00 PM shift and if they had been made aware of the concern they could have assisted Nurse #2 to report the concern with low oxygen saturation to the physician of Resident #4. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING 345433 B. WING ROVIDER OR SUPPLIER 345433 INTY CARE CENTER ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 5 Resident #4 as well as 24 hour shift to shift nursing report sheets from 01/28/15-01/29/15 addressing Resident #4. The DCS stated he noted the physician of Resident #4 had not been notified of the low oxygen saturation until the morning of 01/29/15. The DCS stated the physician should have been immediately called when oxygen saturation was noted at 62% on 01/28/15. The DCS stated he had been in touch with Nurse #2 to inquire about this and Nurse #2 stated she did not call the physician to report the low oxygen saturation because she had been so busy managing the care of residents on the unit during her shift on 01/28/15. The DCS stated there were other nurses present on 01/28/15 during the 3:00 PM-11:00 PM shift and if they had been made aware of the concern with low oxygen saturation to the physician of Resident #4. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN F 282 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. F 282 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to feed a resident according to her most recent assessment and feeding plan that had been developed following a modified barium swallow study for 1 of 1	FERCENCIES CORRECTION (X1) PROVIDERSUPPLIERCLA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING BVING 345433 B. VING STREET ADDRESS, CITY, STATE, 2P CODE BV VALEY HIDEAWAY DRIVE HAYESVILLE, NC 28904 NTY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES REQUATORY OR LSC IDENTIFYING INFORMATION) NE PROVIDERS PLAN OF CORRECTION REQUATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 F 157 Resident #4 as well as 24 hour shift to shift nursing report sheets from 01/28/15-01/29/15 addressing Resident #4. The DCS stated the notified of the low oxygen saturation until the morning of 01/28/15. The DCS stated the physician should have been immediately called when oxygen saturation because she had been no tourg do the 100 CORPC Stated the physician of Resident #4. The DCS stated the physician the DCS stated the physician to Resident #4. The DCS stated the physician to call the physician to report the low oxygen saturation because she had been no tourg do the 100 CORPC STATE ON CORPC TOTE stated she did not call the physician of Resident #4. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN F 282 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed feed are sident according to her most recent assessment and feeding plan that had been developed following a modified barium swallow study for 1 of 1	

Event ID: 92L311

Facility ID: 923105

If continuation sheet Page 6 of 15

							NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	I Y	ATE SURVEY OMPLETED
			A. BUILDIN	IG			0
		245422	B. WING				С
		345433	B. WING_				01/29/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
	JNTY CARE CENTER			86	S VALLEY HIDEAWAY DRIVE		
DEAI CO				HAYESVILLE, NC 28904			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 282	Continued From page						
F 202			F 2	82			
		ses including history of a			Therapist was completed 2/12/15 by the	ne	
	stroke, attention/conc				Director of Clinical		
		t recent Minimum Data Set			Services (DCS) Assistant Director of		
		2/22/14 noted the resident			Clinical Services (ADCS) and Nurse		
		d cognition and requiring			Supervisor. Three residents that were	•	
		on assistance for eating.			recommended to have one-on-one		
		a mechanically altered and			assistance were screened by the Spee		
	therapeutic diet. Res	•			Therapist 2/12/15 thru 2/13/15 to ident		
		included the problem of			continued need for assistance and/or t		
	activity of daily living				make further recommendations. Care		
	resident requiring extensive assistance with various ADL including eating. The care plan				Plans and Kardexes for these resident	IS	
	-				were reviewed and/or updated by the		
		or weight loss, related to a			DCS/Nurse Supervisor. Responsible	d	
		diet and varied intake, tion dated 11/05/14 for			party was notified of any recommende changes by the Nurse Supervisor 2/12		
		y (ST) services 5 days a			thru 2/13/15.	./15	
		dysphagia, a downgraded			unu 2/13/15.		
		is and a recommended			C. The Director of Clinical Services/Nu	ireo	
		low (MBS) for dysphagia.			Supervisor in-serviced licensed staff a		
					Certified Nursing Assistants regarding	nu	
	Review of the medica	al record revealed an			following the resident's care plan in		
		py screen dated 11/06/14			relation to the required observation an	d/or	
		esident #2 with coughing, a			assistance during meal times 2/4/14 th		
		eyes noted during food			2/15/15. The DCS in-serviced the spe		
		downgraded to pureed			therapist on 2/13/15 regarding directly		
		was ordered and skilled ST			communicating to the DCS/ADCS rela		
	-	ed. Review of a MBS report			to any resident that requires and/or is		
		led that according the to the			recommended to have one-on-one		
		portedly shoveled food in			assistance during meals upon		
		ite, had a decreased ability			identification of such. The Director of		
		y and displayed a decline in			Clinical Services and/or Nursing		
	-	s when unsupervised.			Supervisor will perform Quality		
		y it was documented the			Improvement Monitoring of residents		
		ktremely cautious with her			requiring one-on-one assistance durin	g	
		he knew she was being			meal times to ensure one-on-one	-	
		giver who accompanied the			assistance is provided. Quality		
		as saying that this was not			Improvement Monitoring will be condu	cted	
	-	he was unsupervised she			randomly during meal times 5 times a		

Facility ID: 923105

If continuation sheet Page 7 of 15

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
		345433	B. WING		C 01/29/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•
CLAY COL	JNTY CARE CENTER			86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 282	Continued From page	97	F 28	32	
extremely large boluses, and choking episodes. T that given the resident's inhibition and history of in		s. The report recommended it's cognitive deficits, lack of		8 weeks, and then 1 time p months and/or until substa compliance is obtained. D. The results of the Qualit	ntial
	receive 1 to 1 supervision during meals with assistance if needed to ensure that the patient utilized small individual bites of food and sips of fluid. It further recommended that if she was unable to do this with 1 to 1 supervision that she be fed all oral intake as noncompliance with compensatory strategies placed her at a greater			Monitoring will be reported Assessment Performance Committee by the Director Services until substantial c obtained. The Quality Ass Performance Improvement	to the Quality Improvement of Clinical compliance is essment t Committee
	risk for aspiration. Review of an individu 11/13/14 and complet performed the MBS s instruction for 1 to 1 s patient if she was una	alize feeding plan, dated ted by the consultant who tudy, documented supervision and to feed the		members consist of but no Executive Director, Director Services, Assistant Director Services, Wound Care Nur Director, Social Service, M Director, and Director of M Assessment Nurse	or of Clinical or of Clinical rse, Medical aintenance
	filed in the medical re the kardex binder at t with the feeding plan undated nurse tech in which in the eating se	cord and a copy was filed in he nursing station. Filed in the kardex binder was an formation kardex form action was checked "set up" aff." The "supervision"			
	fed by caregivers due comply with compens sips, alternate solids/ using no straws). Re	signed by the facility's), that Resident #2 was to be to her being unable to satory strategies (small bites, liquids at a 2 to 1 ratio and view of a ST discharge 4/14 revealed the resident			

Facility ID: 923105

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 02/23/2015 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345433	B. WING		a	C 1/29/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
	JNTY CARE CENTER		4	36 VALLEY HIDEAWAY DRIVE		
			1	HAYESVILLE, NC 28904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 282	tactile cues, caregiver with a ratio of 1 to 2 s caregivers reduce the teaspoons and caregi strategies to prevent a documented discharg included the resident documented that the and discussed over th consultant. An observation on 01 Resident #2 was seat restorative dining root at her table and no st NA #1 was seated at residents and feeding Resident #2's back w was eating a pureed of large amount of puree hands and face. NA at the restorative dining table where NA #1 was another resident at th Resident #2 was obse potatoes with a fork b family member gave to nutritional shake obta facility, which she dra seated at the other ta residents. At 1:00 PM the restorative dining member that the nutri outside the facility hav resident could drink it shake from the resider	rs alternate solids to liquids olids with 1 liquid, e bolus size to 1 to 2 vers employ compensatory aspiration. The ST e recommendations which to be fed. The ST MBS study was completed be phone with the ST /29/15 at 12:50 PM revealed red for lunch in the m with three other residents aff members at the table. another table with two other one of those residents. as to NA #1. Resident #2 diet with her hands with a ed green peas noted on her #2 was observed entering room and approaching the as seated to speak to at table. At 12:56 PM erved being fed mashed y a family member and the the resident a container of a ined from outside the nk. NA #1 and NA #2 were ble feeding two other <i>I</i> the ST was observed in room telling the family tional shake brought from d to be thickened before the . The ST removed the	F 282			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 02/23/2015 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. /	CONSTRUCTION		X3) DATE S COMPL	SURVEY ETED
		345433	B. WING			C 01/2	9/2015
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
CLAY COL	INTY CARE CENTER		8	6 VALLEY HIDEAWAY DRIVE	E		
			F	IAYESVILLE, NC 28904			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	Ē	(X5) COMPLETION DATE
F 282	directing this was still sometimes the reside feed her, refused to in and would rather eat staff had not informed swallowing concerns. had poor short term in awareness which was supervision. An interview on 01/29 revealed NA #1 was of well. He stated they to restorative dining room knew what was require assistance for residen binder at the nursing s #2 ate a pureed diet, liquids and could eat it time, but if her intake cueing. He stated som her which she would up An interview on 01/29 interim director of clim revealed that a reside supervision with meal to be with that person busy feeding the other dining room would no supervision for Reside with the interim DCS of revealed there was no #2's medical record to	e wrote in November 2014 active. She stated nt would refuse to let staff idependently use utensils with her hands. She stated I her recently of any She stated this resident nemory and poor safety is why she needed the 1/15 at 1:40 PM with NA #2 on orientation and doing very both were assigned to the m for lunch. He stated NAs red regarding feeding its by looking at the kardex station. He stated Resident drank honey thickened independently most of the was poor she required metimes staff had to feed usually accept. 1/15 at 2:47 PM with the ical services (DCS) ent requiring 1 to 1 is meant that someone had . He stated the NA who was r resident in the restorative	F 282				
F 309 SS=D			F 309			:	2/17/15

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 02/23/2015 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345433	B. WING			C / 29/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				86 VALLEY HIDEAWAY DRIVE		
CLAY COL	JNTY CARE CENTER			HAYESVILLE, NC 28904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From page	10	F 30	99		
	provide the necessary or maintain the higher mental, and psychoso	eceive and the facility must v care and services to attain st practicable physical, ocial well-being, in comprehensive assessment				
	by: Based on observation and staff interviews th physician orders prior sampled residents. (Resident #4)	is not met as evidenced ns, medical record review e facility failed to obtain to use of oxygen for 1 of 3		 A. Resident #4 no longer resides at facility. B. All Residents have the potential t affected by this citation. A review of current residents was completed by Director of Clinical Services (DCS). 	o be f	
	with diagnoses which dementia without beh	itted to the facility 04/30/12 included: dysphagia, avioral disorder and of physician orders in the sident #4 on 01/28/15		Director of Clinical Services (DCS), Assistant Director of Clinical Service (ADCS), and Nurse Manager on 2/1 to identify residents that are on oxyg have a current order for oxygen. No issues were identified at that time. C. The DCS/Nurse Supervisor in-se nursing staff on completing the Situa	2/15 gen o	
	respond when spoker pulse oximeter indicat 65% with 90-100% sa on room air. Residen oxygen at the time of entered the room at 3	er back with a pulse nich readily assesses d pulse) on her finger. d to be sleeping and did not n to. The reading on the ted an oxygen saturation of turation a normal reading		Background Assessment Request (form with a change in resident cond include notification of the physician, responsible party of the change of condition on 2/4/15 thru 2/15/15. Th in-service also included that prior to applying oxygen to the resident the licensed nurse must notify the physi and obtain an order. New licensed r employees will be educated on com of the SBAR form with resident chan condition to include notification of the	SBAR) ition to nis cian nurse pletion nge in	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		IO. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G	. ,	IPLETED
						С
		345433	B. WING			1/29/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
CLAY CO	UNTY CARE CENTER			86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ACTION SHOULD BE TO THE APPROPRIATE	COMPLETIO
F 309	Continued From page	e 11	F 30	09		
		/ does." NA #3 removed the		physician, responsible p	arty/resident and	
		ger of Resident #4 and		obtaining an order for ox	-	
		aware of the low oxygen		applying it to a resident		
	saturation and was go	oing to call the physician.		by the DCS/Nurse Supe		
	0 04/00/45 10.001			DCS/Nurse Supervisor	-	
	AM-3:00 PM on 01/28	PM Nurse #1 (on duty 7:00		Quality Improvement Mo resident's to identify if th		
		en concentrator to the room		and then check the med		
	of Resident #4. On 0			current order 5 times a v		
		erved in bed with a nasal		then 3 times a week for		
	cannula in place with	oxygen being administered		times a week for 8 week	s, and then 1 time	
		On 01/28/15 at 4:45 PM		a week for 6 months and		
	Nurse #2 (on duty 3:0			substantial compliance i	s obtained.	
		hen oxygen saturation levels cked on Resident #4 two		D. The results of the Qu	uolity.	
		ere obtained; one at 62%		Improvement monitoring	-	
		se #2 stated the low oxygen		to the Quality Assessme		
		issue for Resident #4 but,		Improvement Committee		
		was being administered via		DCS/Nurse Supervisor	until substantial	
		liters per minute. Nurse #2		compliance is obtained.		
		Resident #4 was not feeling		Assessment performance		
	well and that she wou			Committee consists of b		
		01/28/15 at 5:35 PM Nurse ed Resident #4's oxygen		the Executive Director, I Wound Care Nurse, Me		
		obtained a reading of 71%		Minimum Data Assessm		
		flow rate from 2 liters per				
		minute. On 01/28/15 at 6:08				
		observed in bed with oxygen				
		minute. A pulse oximeter				
		finger of Resident #4 with a				
		uration reading of 80%.				
	Nurses documentatio	on in the medical record of				
	Resident #4 indicated					
		:00 PM This writer informed				
		ell and is in bed. Vital signs				
	-	9, oxygen saturation at 62%.				
	This writer informed s					
	concentrator. writer	then started oxygen at 3				

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		D HUMAN SERVICES				FORM	: 02/23/2015 APPROVED		
CENTERS FOR MEDICARE & N STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
345433			B. WING			C 01/29/2015			
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE)E			
CLAY COU	JNTY CARE CENTER			86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904					
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE			
F 309	PM. Oxygen saturation minute via nasal canning 01/28/15 11:00 PM V 99.7, pulse 108, 81% minute via nasal canni 01/29/15 5:00 AM Re- respirations at times. 2 liters per minute via On 01/29/15 at 9:45 A observed in a geri cha elevated. Resident # and appeared to be c 01/29/15 at 9:50 AM R the start of her shift of had checked the oxyg #4 twice and both tim 90s. Nurse #3 was of oxygen saturation of R the interview and the pulse oximeter was 8 was going to call the p and let him know her On 01/29/15 at 9:50 A reporting the concern conversation to the pl noting the resident ha saturations on 01/28/ saturation was curren obtained from the phy X-ray and to begin ox Immediately after the physician oxygen was	ration up to 81% at 7:30 on at 91% on 4 liters per nula. Will continue to fital signs: Temperature saturation on 3 liters per nula. Will monitor. esident resting in bed, rapid Oxygen saturation 94% on nasal cannula. AM Resident #4 was air with the back of the chair 4 was not wearing oxygen omfortably resting. On Nurse #3 stated that since n 01/29/15 at 7:00 AM she gen saturation of Resident es the levels were in the bserved checking the Resident #4 at the time of reading displayed on the 6%. Nurse #3 stated she ohysician of Resident #4 status. AM Nurse #3 was overheard via a telephone hysician of Resident #4 d experienced low oxygen 15 and that the oxygen tly at 86%. Orders were visician for lab work, a chest ygen at 2 liters per minute.	F 309						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 02/23/2015 APPROVED 0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345433	B. WING		_	C 01/29/2015		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
CLAY COUNTY CARE CENTER			86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Resident #4 was inter he had not been calle Resident #4 until 01/2 nurses notes in the m indicating low oxygen were read to the MD a have been notified im oxygen saturation was because 62% is such have had staff warm t recheck the reading w her ear lobe for accur reading was truly at 6 staff to implement use respiratory distress ar concern. The MD sta saturation readings in reported in the conver he was called at 9:50 because Resident #4 the low saturation was awaiting results of the assess the situation. On 01/29/15 at 3:15 F beginning of her shift told Resident #4 had oxygen saturation. No been told the oxygen in the 60s-80s on 01/2 relayed that also to th called at 9:50 AM.	PM the physician (MD) of viewed. The MD indicated d about the condition of 19/15 at 9:50 AM. The edical record of Resident #4 saturation on 01/28/15 and he stated he should mediately if the resident's is at 62%. The MD stated a low reading he would he resident's hands and/or vith the pulse oximeter on acy. The MD stated if the 2% he would have expected e of oxygen to prevent that then call to report the ted the specific oxygen the 60s-80s had not been rsation with Nurse #3 when AM. The MD stated that was not routinely on oxygen is of concern and he was e chest X-ray and lab work to PM Nurse #3 stated at the on 01/29/15 she had been been on oxygen due to low urse #3 stated if she had saturation levels had been 28/15 she would have e physician when he was	F	309				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/23/2015 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345433	B. WING			C 01/29/2015	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CLAY COUNTY CARE CENTER					6 VALLEY HIDEAWAY DRIVE IAYESVILLE, NC 28904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	JNTY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	309			

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