PRINTED: 03/28/2025 FORM APPROVED OMB NO. 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 _	B. WING		C 02/27/2025	
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 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	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD B THE APPROPRI		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	investigation survey withrough 02/27/25. The compliance with their Emergency Prepared INITIAL COMMENTS A recertification and survey was conducted 02/27/25. Event ID# intakes were investigation.	complaint investigation d from 02/24/25 through M18911. The following ated: NC00221254 and	F(000			
F 636 SS=D	did not result in defici Comprehensive Asse CFR(s): 483.20(b)(1)(1)(1)(1)(1)(2)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	ssments & Timing (2)(i)(iii) sessment duct initially and periodically	Fé	536		·	3/25/25
ARORATORY.	functional capacity. §483.20(b) Comprehe §483.20(b)(1) Reside A facility must make a assessment of a resid goals, life history and resident assessment by CMS. The assess the following: (i) Identification and of (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision.	ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ement must include at least lemographic information	RF	TITLE			X6) DATE

Electronically Signed 03/21/2025

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345433	B. WING		C 02/27/2025		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904	•		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION		
F 636	(vi) Mood and behav (vii) Psychological we (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutriti (xii) Skin Conditions. (xii) Activity pursuit. (xiv) Medications. (xv) Special treatmer (xvi) Discharge planr (xvii) Documentation regarding the additio on the care areas trighte Minimum Data Sc (xviii) Documentation assessment. The as include direct observ with the resident, as licensed and nonliced members on all shifts §483.20(b)(2) When timeframes prescribed chapter, a facility mulassessment of a resist imeframes specified through (iii) of this seprescribed in §413.3 apply to CAHs. (i) Within 14 calendal excluding readmission significant change in mental condition. (For "readmission" means	ior patterns. ell-being. ning and structural problems. s and health conditions. onal status. Ints and procedures. Intig. Integrate of summary information Intig. Integrate of summary information Int	F 63	6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345433	B. WING		C 02/27/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/21/2023	
	10 715 21 1 01 1 001 1 2121 1			86 VALLEY HIDEAWAY DRIVE		
CLAY COUNTY CARE CENTER				HAYESVILLE, NC 28904		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475	
F 636	Continued From page	÷ 2	F 636	3		
		is not met as evidenced				
	facility failed to complete (CAA) comprehensive causes and contributing areas for 2 of 8 resident ulcers and unnecessed #46 and #51). Findings Included: a. Resident #46 was 10/29/24 with diagnostroke and end-stage. Review of Section V (admission Minimum Endots)	CAA Summary) from the		Resident #46 admission Minimum Data Set (MDS) dated 11/04/2024 MD licensed nurse to reflect accurate pressure ulcer. The MDS Coordinator not provide any information in the anal for possible causes, contributing factor that triggered the CAA. Resident #51 annual MDS dated 12/04/2024 by MDS license nurse to reflect accurate psychotropic medications. The MDS Coordinator did not provide any information in the analysis for possible causes, contributing factors, that trigger the CAA. 2. A quality review of current residents with pressure ulcers was conducted to ensure comprehensive assessment was	did ysis rs, S	
	not provide any inform findings that describe #46's problem, possible factors, and risk factor area. It was noted on pressure ulcers would	pleted the assessment did nation in the analysis of d the nature of Resident ole causes, contributing rs for the triggered care at the CAA summary that d be addressed in the care #46 admitting with wounds.		completed accurately in regards to possible causes, contributing factors, to triggered the CAA by MDS director/designee by 03/24/2025. A quareview of current residents with psychotropic medications was conduct to ensure comprehensive assessment was completed accurately to reflect psychotropic medications by the MDS	ality	
	11/28/22 with diagnos	•		director / designee by 03/24/2025. Any concerns were addressed as identified.		
	Review of Section V (annual Minimum Data revealed the care are	CAA Summary) from the a Set (MDS) dated 12/04/24		3. Current licensed MDS nurses were re-educated by RMDS director on 02/27/2025 and ongoing to componen this regulation with emphasis on ensur residents comprehensive assessments	ts of ing	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345433	B. WING	B WING		C		
NAME OF D	20//050 00 01/00/ 150	040400	1 2:				27/2025	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CLAY COL	JNTY CARE CENTER			86	S VALLEY HIDEAWAY DRIVE			
02/11/000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			H	AYESVILLE, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 636	Continued From page	÷ 3	F 6	636				
	MDS Coordinator who did not provide any in findings that describe #51's problem, possit factors, and risk factors, and r	o completed the assessment formation in the analysis of d the nature of Resident ole causes, contributing ors for the triggered care in the CAA summary that ion use would be addressed in 02/27/25 at 11:24 AM, the olained when she first started it understand the CAA or ecompleted for esments. She stated she is should be included in the ind for the more recent MDS d started adding more in the CAA for the care. The MDS Coordinator reculcer care area that the that triggered for have a comprehensive		330	and the Care area assessments (CAA) are completed correctly per federal guidelines. 4. Licensed MDS nurse/designee to conduct quality monitoring for accurate comprehensive assessments and CAA weekly x 4 weeks, then monthly x 1 mond PRN as indicated ensuring resider comprehensive assessments are completed correctly per federal guidelines. The Quality Assurance Performance improvement committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical director, maintenance Director, Housekeeping Services, dietary Manager and Minimum data Set Nurse and minimum of one direct care giver. The MDS license nurse will report findings the Quality Assurance Performance Improvement meeting monthly for three months. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings we quarterly monitoring by the Regional	□s onth ots ger, co e		
F 641 SS=E	Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy		F€	541	Director of MDS/ designee. 5. 03/25/2025		3/25/25	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345433	B. WING _			C 02/27/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		02/21/2023	
				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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTII CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From page	e 4	F 6	41			
	resident's status. This REQUIREMENT by:	et accurately reflect the is not met as evidenced iew and staff interviews, the		1. Resident #1, #51, #63, #	£13 #65 #24		
		ately code Minimum Data		and #47 MDS were audited			
		ents in the areas of bed rails		in the areas of physical rest			
		of 12 sampled residents		use of bedrails by the Region			
		restraints, respiratory care		Nurse on 02/27/2025.			
	and unnecessary me	dications (Residents #1,					
	#51, #63, #13, #65, #	¹ 24, and #47).		2. A quality review was com	•		
				current residents□ MDSs in			
	Findings included:			bed rail restraints to validate			
				recent MDS assessment ha			
		admitted to the facility on		coded to accurately reflect t			
	_	ses that included history of		the residents by the Region	al MDS on		
		uscle weakness and left		02/27/2025.			
	shoulder pain.			An ADHOC Quality Assuran			
	The second and a Minimum	D-4- O-4 (MDO) -1-41		Performance Improvement			
		m Data Set (MDS) dated		was held by 02/28/2025 to f			
	01/19/25 revealed Re			approve a plan of correction	i for the		
	_	d substantial/maximum nobility. The MDS indicated		deficient practice.			
		physical restraint daily and		3. The Regional MDS Coord	dinator		
		as the type of restraint		educated the new MDS Cook			
	utilized.	as the type of restraint		accurately coding of bedrail			
	dillizod.			restraints 02/27/2025.	3 and		
	During an observation	n and interview on 02/25/25		10011411116 02/21/2020.			
		ed rails were observed in		4. Licensed MDS nurse/des	ianee to		
		n each side of Resident #1's		conduct quality monitoring f	-		
		plained she used the bed		bedrails and restraints asse			
		self when lying in bed and as		weekly x 4 weeks, then mor	nthly x 1 month		
	an aid when pulling h	erself up to sit on the side of		and PRN as indicated ensu	ring residents		
	the bed.			comprehensive assessmen			
				completed correctly per fede			
		n 02/27/25 at 11:24 AM, the		guidelines. The Quality Ass			
		nfirmed that the quarter bed		Performance improvement			
		nt #1 were for independent		members consist of but not			
	bed mobility and not	restraints. The MDS		Administrator, Director of No	ursing, Unit		

Facility ID: 923105

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345433	B. WING _				C / 27/2025
	ROVIDER OR SUPPLIER	,	•	86	TREET ADDRESS, CITY, STATE, ZIP CODE 6 VALLEY HIDEAWAY DRIVE AYESVILLE, NC 28904	, 32	
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	a strain page 6		F 6	641	Managan Casial Caminas Madisal		
	question on the MDS rail use and the quart	d she misunderstood the assessment regarding bed terly MDS assessment dated t #1 was coded incorrectly.			Manager, Social Services, Medical director, maintenance Director, Housekeeping Services, dietary Managand Minimum data Set Nurse and minimum of one direct care giver. The		
	During an interview on 02/27/25 at 1:34 PM, the Administrator explained the facility did not use restraints and bed rails were used only as personal bed mobility devices. The Administrator stated he expected MDS assessments to be completed accurately. 2. Resident #51 was admitted to the facility on 11/28/22 with diagnoses that included debility (physical weakness), respiratory failure and asthma with acute exacerbation (sudden worsening of symptoms).				MDS license nurse will report findings the Quality Assurance Performance Improvement meeting monthly for three months. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement	e g⊡s	
					Committee monthly. Quality Monitoring schedule modified based on findings w quarterly monitoring by the Regional Director of MDS/ designee.		
	10/11/24 revealed Reimpairment in cognition partial/moderate assist The MDS indicated F	stance with bed mobility. Resident #51 used a physical d rail was marked as the			5. 03/25/2025		
	12/04/24 revealed Reimpairment in cognition partial/moderate assist The MDS indicated F	stance with bed mobility. Resident #51 used a physical d rail was marked as the					
	Aide #1 and Nurse A	ew on 02/27/25 with Med ide #1 both stated Resident drails for independent bed oning.					

		IDENTIFICATION NI IMPED		E CONSTRUCTION	COMPLETED	
		345433	B. WING		C 02/27/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904	02/21//2020	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 641	MDS Coordinator or rails used by Resid bed mobility and not Coordinator explair question on the MD rail use and the qua 12/04/24 for Resided During an interview Administrator explair restraints and bed in personal bed mobil stated he expected completed accurated 3. Resident #63 wa 02/15/24 with diagrartery disease and weakness. The quarterly Minin 10/11/24 revealed fimpairment in cognipartial/moderate as The MDS indicated restraint daily and by type of restraint util. The quarterly Minin 11/12/24 revealed fimpairment in cognipartial/moderate as The MDS indicated restraint daily and by type of restraint util. During an interview.	on 02/27/25 at 11:24 AM, the onfirmed that the quarter bed ent #51 were for independent of restraints. The MDS need she misunderstood the DS assessment regarding bed earterly MDS assessment dated ent #51 was coded incorrectly. If on 02/27/25 at 1:34 PM, the ined the facility did not use rails were used only as ity devices. The Administrator MDS assessments to be early. If on 02/27/25 at 1:34 PM, the ined the facility did not use rails were used only as ity devices. The Administrator MDS assessments to be early. If on 02/27/25 at 1:34 PM, the ined the facility did not use rails were used only as ity devices. The Administrator MDS assessments to be early. If on 02/27/25 at 1:34 PM, the ined the facility did not use rails were used only as ity devices. The Administrator MDS assessments to be early. If on 02/27/25 at 1:34 PM, the ined the facility did not use rails were used only as ity devices. The Administrator MDS assessments to be early. If on 02/27/25 at 1:34 PM, the ined the facility did not use rails were used only as ity devices. The Administrator MDS assessments to be early. If on 02/27/25 at 1:34 PM, the ined the facility on the facili	F 64			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345433	B. WING		C 02/27/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904	, OZIZITZOZO	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 641	bed mobility and no Coordinator explain question on the MD rail use and the quadated 10/11/24 and was coded incorrect. During an interview Administrator explain restraints and bed restraints and restraint of volunting the lower half of the condition of shorten muscles, tendons, of the deformity, and riganxiety, major depressions and restraints blood vessel Review of the quart dated 2/3/25 reveals as a restraint used of Review of the care Resident #13 has a (ADL) self-care perfective mobility. Go maintain the currents	ent #63 were for independent at restraints. The MDS ed she misunderstood the S assessment regarding bed arterly MDS assessments 11/12/24 for Resident #63 atly. on 02/27/25 at 1:34 PM, the sined the facility did not use ails were used only as a sty devices. The Administrator MDS assessments to be selly. s admitted to the facility on osis that included paraplegia derized by the loss or other tissues, often leading glidity of joints) right hip, essive disorder, dementia, and cerebrovascular disease all conditions that affect the les and blood flow).	F 641			

		' '			(X3) DATE SURVEY COMPLETED	
	345433	B. WING _			C 02/27/2025	
			STREET ADDRESS, CITY, STATE, ZIP O 86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904	•	<u> </u>	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
mobility included Requarter rails to max turning and reposition. Review of the physic revealed that the faquarter rails to promindependence with incontinence care. An interview on 02/MDS Coordinator remisunderstood the answered the quest now she knows the marked under restrated for independerestraint. An interview on 02/Director of Nursing expectations with Mathematical that MDS assessment further revealed that restraints, and the personal mobility defended for the personal mobility.	esident #13 uses bilateral imize independence with oning in bed. dician's orders dated 10/6/21 cility would maintain bilateral note the highest level of bed mobility, positioning, and 27/25 at 11:24 AM with the evealed that she question and realized she tion wrong. She stated that by should not have been aints and the bed rails were not bed mobility and not as a 27/25 at 1:06 PM with the (DON) revealed that her IDS accuracy were to follow redure of the facility. 27/25 at 1:34 PM with the led that his expectation was ents be coded accurately. He at the facility had not used bed rails were used as evices. Is admitted to the facility on is that included muscle iness on feet, lack of bnormalities of gait and	F	541			
	ROVIDER OR SUPPLIER SUMMARY: (EACH DEFICIEN REGULATORY O Continued From pa mobility included Re quarter rails to max turning and repositi. Review of the physi revealed that the fa quarter rails to pron independence with incontinence care. An interview on 02/ MDS Coordinator re misunderstood the answered the quest now she knows the marked under restra used for independe restraint. An interview on 02/ Director of Nursing expectations with M the policy and proce An interview on 02/ Administrator reveal that MDS assessme further revealed tha restraints, and the te personal mobility de 5. Resident #65 wa 6/7/24 with diagnos weakness, unstead coordination, and a mobility. Review of the quart	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 mobility included Resident #13 uses bilateral quarter rails to maximize independence with turning and repositioning in bed. Review of the physician's orders dated 10/6/21 revealed that the facility would maintain bilateral quarter rails to promote the highest level of independence with bed mobility, positioning, and incontinence care. An interview on 02/27/25 at 11:24 AM with the MDS Coordinator revealed that she misunderstood the question and realized she answered the question wrong. She stated that now she knows they should not have been marked under restraints and the bed rails were used for independent bed mobility and not as a restraint. An interview on 02/27/25 at 1:06 PM with the Director of Nursing (DON) revealed that her expectations with MDS accuracy were to follow the policy and procedure of the facility. An interview on 02/27/25 at 1:34 PM with the Administrator revealed that his expectation was that MDS assessments be coded accurately. He further revealed that the facility had not used restraints, and the bed rails were used as personal mobility devices. 5. Resident #65 was admitted to the facility on 6/7/24 with diagnosis that included muscle weakness, unsteadiness on feet, lack of coordination, and abnormalities of gait and	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 mobility included Resident #13 uses bilateral quarter rails to maximize independence with turning and repositioning in bed. Review of the physician's orders dated 10/6/21 revealed that the facility would maintain bilateral quarter rails to promote the highest level of independence with bed mobility, positioning, and incontinence care. An interview on 02/27/25 at 11:24 AM with the MDS Coordinator revealed that she misunderstood the question and realized she answered the question wrong. She stated that now she knows they should not have been marked under restraints and the bed rails were used for independent bed mobility and not as a restraint. An interview on 02/27/25 at 1:06 PM with the Director of Nursing (DON) revealed that her expectations with MDS accuracy were to follow the policy and procedure of the facility. An interview on 02/27/25 at 1:34 PM with the Administrator revealed that his expectation was that MDS assessments be coded accurately. He further revealed that the facility had not used restraints, and the bed rails were used as personal mobility devices. 5. Resident #65 was admitted to the facility on 6/7/24 with diagnosis that included muscle weakness, unsteadiness on feet, lack of coordination, and abnormalities of gait and mobility. Review of the quarterly MDS dated 6/7/24	ROUIDER OR SUPPLIER 345433 345433 STREET ADDRESS, CITY, STATE, ZIP 6 SUALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 mobility included Resident #13 uses bilateral quarter rails to maximize independence with turning and repositioning in bed. Review of the physician's orders dated 10/6/21 revealed that the facility would maintain bilateral quarter rails to promote the highest level of independence with bed mobility, positioning, and incontinence care. An interview on 02/27/25 at 11:24 AM with the MDS Coordinator revealed that she misunderstood the question wrong. She stated that now she knows they should not have been marked under restraints and the bed rails were used for independent bed mobility and not as a restraint. An interview on 02/27/25 at 1:06 PM with the Director of Nursing (DON) revealed that he expectation with MDS accuracy were to follow the policy and procedure of the facility. An interview on 02/27/25 at 1:34 PM with the Administrator revealed that his expectation was that MDS assessments be coded accurately. He further revealed that the facility had not used restraints, and the bed rails were used as personal mobility devices. 5. Resident #65 was admitted to the facility on 6/7/24 with diagnosis that included muscle weakness, unsteadiness on feet, lack of coordination, and abnormalities of gait and mobility. Review of the quarterly MDS dated 6/7/24	A BUILDING 345433 ROWDER OR SUPPLIER NOTY CARE CENTER SUMMARY STATEMENT OF DEPICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 Continued From page 8 Continued From page 8 Review of the physician's orders dated 10/6/21 revealed that the facility would maintain bilateral quarter rails to maximize independence with turning and repositioning in bed. Review of the physician's orders dated 10/6/21 revealed that the facility would maintain bilateral quarter rails to promote the highest level of independence with bed mobility, positioning, and incontinence care. An interview on 02/27/25 at 11:24 AM with the MDS Coordinator revealed that she misunderstood the question and realized she answered the question wrong. She stated that now she knows they should not have been marked under restraints and the bed rails were used for independent bed mobility and not as a restraint. An interview on 02/27/25 at 1:34 PM with the Director of Nursing (DON) revealed that her expectations with MDS accuracy were to follow the policy and procedure of the facility. An interview on 02/27/25 at 1:34 PM with the Administrator revealed that this expectation was that MDS assessments be coded accurately. He further revealed that the facility had not used restraints, and the bed rails were used as personal mobility devices. Review of the quarterly MDS dated 6/7/24 Review of the quarterly MDS dated 6/7/24	

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		345433		B. WING		C 02/27/2025	
	NAME OF PROVIDER OR SUPPLIER CLAY COUNTY CARE CENTER		,	8	STREET ADDRESS, CITY, STATE, ZIP CODE 66 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Resident #65 ADL serelated to impaired be Goals included Residurent level of function Interventions for bed #65 uses bilateral quaindependence with turnobility. Review of the physici revealed that the faci quarter rails to promomobility, turning, and An interview on 02/27 MDS Coordinator revisunderstood the quanswered the question now she knows they marked under restraint. An interview on 02/27 Director of Nursing (Dexpectations with MD the policy and procedurate models). An interview on 02/27 Administrator revealed that mDS assessment further revealed that the personal mobility devices.	ans dated 12/10/24 revealed lf-care performance deficit alance, Pain (low back pain). ent # 65, will improve the on through the review date. mobility included Resident arter rails to promote rning, repositioning, and an's orders dated 11/19/24 lity would maintain bilateral ate independence with bed repositioning. 7/25 at 11:24 AM with the ealed that she lestion and realized she on wrong. She stated that should not have been not and the bed rails were bed mobility and not as a 7/25 at 1:06 PM with the loon) revealed that her loon) revealed that her loon and realized she with the loon and realized that her loon and realized that her loon and realized that her loon are to follow lure of the facility.	F	641			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345433	B. WING			C 02/27/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904		02/2//2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 641	dementia, Alzheimer chronic obstructive procession of the Medinote dated 12/30/24 evaluated for chest of MD's physical examungs were clear and related to a cough at The MD recommend and no new physicial the treatment of pne A review of the physical through 1/17/25 revex-ray or antibiotic mappeumonia. A review of Resident Data Set (MDS) asserevealed pneumonia diagnosis. The MDS revealed Resident # was no indication not During an interview MDS Coordinator concurrency MDS asseredated 1/17/25. The Indetermining a resider results, and nurse prof Resident #24 med Coordinator revealed documentation to su active diagnosis during the MDS asserted of the MDS asserted th	24's diagnoses included r's disease, pneumonia, and pulmonary disease. Ical Doctor (MD) progress revealed Resident #24 was congestion and cough. The revealed Resident #24's difference was no complications to the time of the evaluation. Bed to continue monitoring an orders were provided for tumonia. Ician orders from 12/30/24 ealed no orders for a chest redication for the treatment of the treatment of the was coded as an active to the was not taking and there are to firm the was not taking and there are to for the use of antibiotics. In 02/27/25 at 11:43 AM the confirmed she completed the sement for Resident #24 MDS Coordinator revealed for ent's active diagnoses, she orders, labs and diagnostic rogress notes. After review dical records the MDS	F 64	41			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345433	B. WING_			C 02/27/2025
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904	ı	02/2//2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 641	Director of Nursing (need to be written do medical record from confirm an active dia not the MDS was incomply an interview of Administrator reveals be coded correct who MDS assessment. 7. Resident #47 was 1/24/25 with diagnost and heart failure. A review of the currect Resident #47 was ta (mg) daily for hypertotwice a day for hypertotwice a day for hypertotwice and heart failure. A review of Resident assessment dated 1, was not coded as an During an interview of MDS Coordinator coadmission MDS assedated 1/31/25. The that when coding active resident's list of resident's list of resident's list of resident assessment dated as was error.	on 02/27/25 at 1:17 PM the DON) revealed there would ocumentation in the resident's a medical care provider to ignosis of pneumonia and if correctly coded. On 02/27/25 at 1:45 PM the end active diagnoses should en completing the resident's admitted to the facility on item including atrial fibrillation on the physician orders revealed king metoprolol 25 milligrams ension and lisinopril 20 mg intension that were started on active diagnosis. On 02/27/25 at 11:33 AM the infirmed she completed the ensment for Resident #47 MDS Coordinator revealed dive diagnosis, she reviewed medications and if they were end to treat hypertension it an active diagnosis and if not	F 6	41		
	DON revealed if curr	on 02/27/25 at 1:17 PM the ent physician's orders or lisinopril for the treatment				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345433	B. WING _			C 02/27/2025	
	ROVIDER OR SUPPLIER JNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COL 86 VALLEY HIDEAWAY DRIVE HAYESVILLE, NC 28904	DE		
(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 CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT		
F 641	Continued From page	: 12	F 6	341			
	During an interview of Administrator reveale be coded correct whe	uld be coded as an active 6. n 02/27/25 at 1:45 PM the d active diagnoses should n completing the MDS					
F 700 SS=D	assessment. Bedrails CFR(s): 483.25(n)(1)-	(4)	F 7	000		3/25/25	
	alternatives prior to in a bed or side rail is us correct installation, us	npt to use appropriate stalling a side or bed rail. If sed, the facility must ensure se, and maintenance of bed t limited to the following					
	, , , ,	the resident for risk of rails prior to installation.					
	bed rails with the resi	the risks and benefits of dent or resident otain informed consent prior					
		that the bed's dimensions e resident's size and weight.					
	and maintaining bed in This REQUIREMENT by: Based on observation interviews the facility assessments to determine the second sec	d specifications for installing		Resident #1, #51 and #1 02/27/2025 bedrails assessm audited and corrected in the bedrail assessments by Direction.	nents were areas of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345433	B. WING _				C 27/2025
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	2172020
				86	6 VALLEY HIDEAWAY DRIVE		
CLAY COL	JNTY CARE CENTER			н	AYESVILLE, NC 28904		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 700	Continued From page	e 13	F 7	700			
	#51 and #13).				Clinical Services to reflect appropriate		
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				needs for bedrails as positioning devic	es.	
	Findings Included:				2. A quality review was completed or		
	1. a. Resident #1 wa	is admitted to the facility on			current resident⊡s bedrail assessment		
		ses that included history of			validate the most recent assessment h	ave	
		nuscle weakness and left			been completed to accurately reflect th	ıe	
	shoulder pain.				status of the residents by the Director	of	
					Clinical Services on 02/27/2025.		
	Review of Resident #1's electronic medical				An ADHOC Quality Assurance		
	record on 02/26/25 revealed the last completed				Performance Improvement Committee		
	bed rail assessment	was dated 11/08/23.			was held by 02/28/2025 to formulate a	nd	
	The average of Minima	on Data Cat (MDC) datad			approve a plan of correction for the		
	01/19/25 revealed Re	ım Data Set (MDS) dated			deficient practice.		
		ed substantial/maximum			3. The Regional Director of Clinical		
	assistance with bed r				Services (RDCS) educated the Director	or of	
	acciotance with boan				Clinical Services (DCS) and the Assist		
	During an observatio	n and interview on 02/25/25			Director of Nursing (ADON) on comple		
		ed rails were observed in			assessments for all bedrails and then t	-	
	the upright position o	n each side of Resident #1's			continue the assessments on admission	n,	
	bed. Resident #1 ex	plained she used the bed			quarterly, significate change, and as		
		self when lying in bed and as			needed 02/27/2025.		
		erself up to sit on the side of			<u></u>		
	the bed.				4. Director of Clinical Services/desig		
	b Dooidont #54	admitted to the facility as			to conduct quality monitoring for accur-	ate	
		admitted to the facility on			bedrails assessments 4 x week x 4		
	11/28/22 with diagnoses that included debility (physical weakness), respiratory failure and				weeks, then 2 x week x 4 weeks, 1 x week x 1 month and PRN as indicated		
	asthma with acute ex	•			ensuring residents bedrail assessment		
	worsening of sympto				are completed correctly per federal	J	
		···- <i>)</i> ·			guidelines. The Quality Assurance		
	Review of Resident #	\$51's electronic medical			Performance improvement committee		
		evealed there were no bed			members consist of but not limited to		
	rail assessments con	npleted since 10/26/23, the			Administrator, Director of Nursing, Unit	i	
		ification and complaint			Manager, Social Services, Medical		
	investigation survey.				director, maintenance Director,		
					Housekeeping Services, dietary Mana	ger,	
	The annual Minimum	Data Set (MDS) dated			and Minimum data Set Nurse and		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
		345433	B. WING _				27/ 2025
	ROVIDER OR SUPPLIER			86	TREET ADDRESS, CITY, STATE, ZIP CODE S VALLEY HIDEAWAY DRIVE AYESVILLE, NC 28904	1 02/	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	impairment in cognitic partial/moderate assis During a joint interview Med Aide #1 and Nur Resident #51 used quindependent bed mol During an interview of Director of Nursing (I policy and procedure it was the responsibil staff to complete bed or at the very least, a was her expectation is policy to ensure bed completed per the fact During an interview of Administrator stated in rail assessments to be policy. 2. Resident #13 was 11/18/14 with diagnosic (a condition characte impairment of voluntain the lower half of the condition of shortenir muscles, tendons, or to deformity, and rigid anxiety, major depression abnormal posture, are (a variety of medical brain's blood vessels).	esident #51 had moderate on and required stance with bed mobility. It won 02/27/25 at 10:11 AM, rese Aide #1 both stated uarter bed rails for bility and repositioning. In 02/27/25 at 1:06 PM, the DON) stated the facility had a in place for bed rail use and ity of administrative nursing rail assessments quarterly nnually. The DON stated it staff would follow the facility rail assessments were bility policy. In 02/27/25 at 1:34 PM, the the was his expectation for bed be completed per the facility admitted to the facility on sis that included paraplegia rized by the loss or any movement and sensation be body), contracture (a log and hardening of lother tissues, often leading dity of joints) right hip, sieve disorder, dementia, and cerebrovascular disease conditions that affect the	F7	700	minimum of one direct care giver. The MDS license nurse will report findings to the Quality Assurance Performance Improvement meeting monthly for three months. The findings of these quality monitoring to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings w quarterly monitoring by the Director of Clinical Services/designee. 5. 03/25/2025	do e g⊡s	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		0.45400	D MINO		С		
NAME OF P	ROVIDER OR SUPPLIER	345433	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	02/27/2025		
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 PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION		
F 700	Continued From page	e 15	F 7	00			
		romote the highest level of ed mobility, positioning, and					
	Review of the bed rai was last completed or	I assessment revealed it n 12/12/23.					
	assessment dated 2/3	rly Minimum Data Set (MDS) 3/25 revealed Resident #13 naximum assistance with					
	Director of Nursing (E breakdown in the con assessments fell thro there was so much of nursing staff. She fur responsibility of admi complete the bed rail that her expectation v	npletion of bed rail ugh the cracks because nange in administrative ther revealed it was the nistrative nursing staff to assessments. She stated was that bed rail be completed quarterly or					
	Administrator reveale	7/25 at 1:34 PM with the d that his expectation for was that they be completed					