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	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clay County Care Center	86 Valley Hideaway Drive Hayesville, NC 28904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on record review and staff interviews the facility failed to complete Care Area Assessments (CAA) comprehensively to address the underlying causes and contributing factors of the triggered areas for 2 of 8 residents reviewed for pressure ulcers and unnecessary medications (Residents #46 and #51). Findings Included: a. Resident #46 was admitted to the facility on [DATE] with diagnoses that included diabetes, stroke and end-stage renal disease. Review of Section V (CAA Summary) from the admission Minimum Data Set (MDS) dated [DATE] revealed the care area for pressure ulcer triggered for Resident #46. The MDS Coordinator who completed the assessment did not provide any information in the analysis of findings that described the nature of Resident #46's problem, possible causes, contributing factors, and risk factors for the triggered care area. It was noted on the CAA summary that pressure ulcers would be addressed in the care plan due to Resident #46 admitting with wounds. b. Resident #51 was admitted to the facility on [DATE] with diagnoses that included debility (physical weakness), respiratory failure and asthma with acute exacerbation (sudden worsening of symptoms). Review of Section V (CAA Summary) from the annual Minimum Data Set (MDS) dated [DATE] revealed the care area for psychotropic medication use triggered for Resident #51. The MDS Coordinator who completed the assessment did not provide any information in the analysis of findings that described the nature of Resident #51's problem, possible causes, contributing factors, and risk factors for the triggered care area. It was noted on the CAA summary that psychotropic medication use would be addressed in the care plan. (continued on next page)

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/25 at 11:24 AM, the MDS Coordinator explained when she first started the position, she didn't understand the CAA or that they needed to be completed for comprehensive assessments. She stated she now understood what should be included in the analysis of findings and for the more recent MDS assessments, she had started adding more pertinent information in the CAA for the care area(s) that triggered. The MDS Coordinator confirmed the pressure ulcer care area that triggered for Resident #46 and the psychotropic medication use care area that triggered for Resident #51 did not have a comprehensive analysis of finding completed. During an interview on 02/27/25 at 1:34 PM, the Administrator stated it was his expectation for CAAs to completed and contain a comprehensive analysis of findings for the triggered care area(s).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of bed rails and diagnoses for 7 of 12 sampled residents reviewed for physical restraints, respiratory care and unnecessary medications (Residents #1, #51, #63, #13, #65, #24, and #47). Findings included: 1. Resident #1 was admitted to the facility on [DATE] with diagnoses that included history of falling, generalized muscle weakness and left shoulder pain. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had intact cognition and required substantial/maximum assistance with bed mobility. The MDS indicated Resident #1 used a physical restraint daily and bed rail was marked as the type of restraint utilized. During an observation and interview on 02/25/25 at 9:15 AM, quarter bed rails were observed in the upright position on each side of Resident #1's bed. Resident #1 explained she used the bed rails to reposition herself when lying in bed and as an aid when pulling herself up to sit on the side of the bed. During an interview on 02/27/25 at 11:24 AM, the MDS Coordinator confirmed that the quarter bed rails used by Resident #1 were for independent bed mobility and not restraints. The MDS Coordinator explained she misunderstood the question on the MDS assessment regarding bed rail use and the quarterly MDS assessment dated [DATE] for Resident #1 was coded incorrectly. 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 [DATE] with diagnoses that included debility (physical weakness), respiratory failure and asthma with acute exacerbation (sudden worsening of symptoms). The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #51 had moderate impairment in cognition and required partial/moderate assistance with bed mobility. The MDS indicated Resident #51 used a physical restraint daily and bed rail was marked as the type of restraint utilized. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #51 had moderate impairment in cognition and required partial/moderate assistance with bed mobility. The MDS indicated Resident #51 used a physical restraint daily and bed rail was marked as the type of restraint utilized. During a joint interview on 02/27/25 with Med Aide #1 and Nurse Aide #1 both stated Resident #51 used quarter bed rails for independent bed mobility and repositioning. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/27/25 at 11:24 AM, the MDS Coordinator confirmed that the quarter bed rails used by Resident #51 were for independent bed mobility and not restraints. The MDS Coordinator explained she misunderstood the question on the MDS assessment regarding bed rail use and the quarterly MDS assessment dated [DATE] for Resident #51 was coded incorrectly. 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. 3. Resident #63 was admitted to the facility on [DATE] with diagnoses that included coronary artery disease and generalized muscle weakness. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #63 had moderate impairment in cognition and required partial/moderate assistance with bed mobility. The MDS indicated Resident #63 used a physical restraint daily and bed rail was marked as the type of restraint utilized. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #63 had moderate impairment in cognition and required partial/moderate assistance with bed mobility. The MDS indicated Resident #63 used a physical restraint daily and bed rail was marked as the type of restraint utilized. During an interview on 02/27/25 at 11:24 AM, the MDS Coordinator confirmed that the quarter bed rails used by Resident #63 were for independent bed mobility and not restraints. The MDS Coordinator explained she misunderstood the question on the MDS assessment regarding bed rail use and the quarterly MDS assessments dated 10/11/24 and 11/12/24 for Resident #63 was coded incorrectly. 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. 47683 4. Resident #13 was admitted to the facility on [DATE] with diagnosis that included paraplegia (a condition characterized by the loss or impairment of voluntary movement and sensation in the lower half of the body), contracture (a condition of shortening and hardening of muscles, tendons, or other tissues, often leading to deformity, and rigidity of joints) right hip, anxiety, major depressive disorder, dementia, abnormal posture, and cerebrovascular disease (a variety of medical conditions that affect the brain's blood vessels and blood flow). Review of the quarterly minimum data set (MDS) dated [DATE] revealed that bed rails were marked as a restraint used daily. Review of the care plan dated 2/10/25 revealed Resident #13 has an activities of daily living (ADL) self-care performance deficit related to decreased cognitive function, paraplegia, and limited mobility. Goals include Resident #13 will maintain the current level of function in ADL through the review date. Interventions for bed mobility included Resident #13 uses bilateral quarter rails to maximize independence with turning and repositioning in bed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 [DATE] with diagnosis that included muscle weakness, unsteadiness on feet, lack of coordination, and abnormalities of gait and mobility. Review of the quarterly MDS dated [DATE] revealed that bed rails were marked as a restraint used daily. Review of the care plans dated 12/10/24 revealed Resident #65 ADL self-care performance deficit related to impaired balance, Pain (low back pain). Goals included Resident # 65, will improve the current level of function through the review date. Interventions for bed mobility included Resident #65 uses bilateral quarter rails to promote independence with turning, repositioning, and mobility. Review of the physician's orders dated 11/19/24 revealed that the facility would maintain bilateral quarter rails to promote independence with bed mobility, turning, and repositioning. 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. 37538 6. Resident #24 was admitted to the facility on [DATE]. Resident #24's diagnoses included dementia, Alzheimer's disease, pneumonia, and chronic obstructive pulmonary disease. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Medical Doctor (MD) progress note dated 12/30/24 revealed Resident #24 was evaluated for chest congestion and cough. The MD's physical exam revealed Resident #24's lungs were clear and there was no complications related to a cough at the time of the evaluation. The MD recommended to continue monitoring and no new physician orders were provided for the treatment of pneumonia. A review of the physician orders from 12/30/24 through 1/17/25 revealed no orders for a chest x-ray or antibiotic medication for the treatment of pneumonia. A review of Resident #24's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed pneumonia was coded as an active diagnosis. The MDS list of high risk medications revealed Resident #24 was not taking and there was no indication noted for the use of antibiotics. During an interview on 02/27/25 at 11:43 AM the MDS Coordinator confirmed she completed the quarterly MDS assessment for Resident #24 dated 1/17/25. The MDS Coordinator revealed for determining a resident's active diagnoses, she reviewed physician orders, labs and diagnostic results, and nurse progress notes. After review of Resident #24 medical records the MDS Coordinator revealed there was no documentation to support pneumonia was an active diagnosis during the MDS assessment dated [DATE] and was incorrectly coded. During an interview on 02/27/25 at 1:17 PM the Director of Nursing (DON) revealed there would need to be written documentation in the resident's medical record from a medical care provider to confirm an active diagnosis of pneumonia and if not the MDS was incorrectly coded. During an interview on 02/27/25 at 1:45 PM the Administrator revealed active diagnoses should be coded correct when completing the resident's MDS assessment. 7. Resident #47 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation and heart failure. A review of the current physician orders revealed Resident #47 was taking metoprolol 25 milligrams (mg) daily for hypertension and lisinopril 20 mg twice a day for hypertension that were started on 1/25/25. A review of Resident #47's admission MDS assessment dated [DATE] revealed hypertension was not coded as an active diagnosis. During an interview on 02/27/25 at 11:33 AM the MDS Coordinator confirmed she completed the admission MDS assessment for Resident #47 dated 1/31/25. The MDS Coordinator revealed that when coding active diagnosis, she reviewed the resident's list of medications and if they were taking medication used to treat hypertension it should be coded as an active diagnosis and if not was error. During an interview on 02/27/25 at 1:17 PM the DON revealed if current physician's orders included metoprolol or lisinopril for the treatment of hypertension it should be coded as an active diagnosis on the MDS. During an interview on 02/27/25 at 1:45 PM the Administrator revealed active diagnoses should be coded correct when completing the MDS assessment.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on observations, record review, and staff interviews the facility failed to complete bed rail assessments to determine the need for bed rail use for 3 of 5 sampled residents (Resident #1, #51 and #13). Findings Included: 1. a. Resident #1 was admitted to the facility on [DATE] with diagnoses that included history of falling, generalized muscle weakness and left shoulder pain. Review of Resident #1's electronic medical record on 02/26/25 revealed the last completed bed rail assessment was dated 11/08/23. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had intact cognition and required substantial/maximum assistance with bed mobility. During an observation and interview on 02/25/25 at 9:15 AM, quarter bed rails were observed in the upright position on each side of Resident #1's bed. Resident #1 explained she used the bed rails to reposition herself when lying in bed and as an aid when pulling herself up to sit on the side of the bed. b. Resident #51 was admitted to the facility on [DATE] with diagnoses that included debility (physical weakness), respiratory failure and asthma with acute exacerbation (sudden worsening of symptoms). Review of Resident #51's electronic medical record on 02/25/25 revealed there were no bed rail assessments completed since 10/26/23, the date of the last recertification and complaint investigation survey. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #51 had moderate impairment in cognition and required partial/moderate assistance with bed mobility. During a joint interview on 02/27/25 at 10:11 AM, Med Aide #1 and Nurse Aide #1 both stated Resident #51 used quarter bed rails for independent bed mobility and repositioning. During an interview on 02/27/25 at 1:06 PM, the Director of Nursing (DON) stated the facility had a policy and procedure in place for bed rail use and it was the responsibility of administrative nursing staff to complete bed rail assessments quarterly or at the very least, annually. The DON stated it was her expectation staff would follow the facility policy to ensure bed rail assessments were completed per the facility policy. During an interview on 02/27/25 at 1:34 PM, the Administrator stated it was his expectation for bed rail assessments to be completed per the facility policy. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47683 2. Resident #13 was admitted to the facility on [DATE] with diagnosis that included paraplegia (a condition characterized by the loss or impairment of voluntary movement and sensation in the lower half of the body), contracture (a condition of shortening and hardening of muscles, tendons, or other tissues, often leading to deformity, and rigidity of joints) right hip, anxiety, major depressive disorder, dementia, abnormal posture, and cerebrovascular disease (a variety of medical conditions that affect the brain's blood vessels and blood flow). Review of the physician's orders dated 10/6/21 revealed that the facility would maintain bilateral quarter bed rails to promote the highest level of independence with bed mobility, positioning, and incontinence care. Review of the bed rail assessment revealed it was last completed on 12/12/23. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 required substantial/maximum assistance with bed mobility. An interview on 02/27/25 at 1:06 PM with the Director of Nursing (DON) revealed the breakdown in the completion of bed rail assessments fell through the cracks because there was so much change in administrative nursing staff. She further revealed it was the responsibility of administrative nursing staff to complete the bed rail assessments. She stated that her expectation was that bed rail assessments were to be completed quarterly or at the very least annually and to follow the facility's policy. An interview on 02/27/25 at 1:34 PM with the Administrator revealed that his expectation for bed rail assessments was that they be completed per the facility policy.