STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345024	A. BUILDING _____ B. WING _____	06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS NURSING CENTER INC	5229 APPOMATTOX ROAD PLEASANT GARDEN, NC 27313

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to transfer Resident#48 using a mechanical lift device as ordered and as developed in the plan of care. This failure resulted in a fractured lower right leg. This was evident in 1 of 3 residents in the sample reviewed for accidents. Findings included: Resident# 48 has cumulative diagnoses which included osteoarthrosis (a common form of arthritis), a history of a fracture in the upper arm and moderate to severe diffused osteopenia. Osteopenia is a condition where bone mineral density is lower than normal. Review of the Minimum Data Set (MDS) dated 4/23/12 revealed Resident #48 had impaired cognition and required extensive assistance for care. Resident#48 ' s balance standing was unsteady and only stabilized with staff assistance. Review of the careplan (undated) located in the Kiosk (computer system used by the nursing assistants to guide and document care) revealed	F 323	**This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that this Facility violated any federal or state regulation or failed to follow any applicable standard of care.** 07/02/12 F323 1. On May 22, 2012 upon discovering the failure to use the mechanical lift for Resident #48 all staff on duty was in-serviced on properly following policy, procedure and adhering to residents' individual care plan regarding transfers on 5/22/12. Resident #48 is transferred using the mechanical lift device (Hoyer) by CNA's and documented in the Kiosk per Resident #48's care plan. Staff nurse supervises and monitors transfers of resident #48 and documents on Hoyer Lift Daily Audit Form on 6/14/12. CNA #3 is no longer employed by the facility. cont→	

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

Cheryl Clapp-Coleman Administrator 07/09/12

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.

PB.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345024	A. BUILDING _____ B. WING _____	06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS NURSING CENTER INC	5229 APPOMATTOX ROAD PLEASANT GARDEN, NC 27313

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F 323	Continued From page 1 approaches that included" _____[name of mechanical lift) for all transfers." Review of the computerized "Physician order list" form revealed orders for a _____[name of mechanical lift) for transfers since 1/20/12. Review of the nurses notes dated 5/20/12 at 11:10 p.m. revealed a nursing assistant (NA) summoned the nurse that there had been an accident. Two NAs reported that they were getting Resident #48 in the bed and her foot got caught. Resident #48 sustained a skin tear and her ankle hurts. The nurse assessed the resident and noted a 4 cm (centimeter) by 5 cm skin tear to the outer aspect of the right calf. A bruise was noted to the top of the lower leg. The nurse practitioner (NP) was notified and NP orders included an x-ray of the right leg and ankle, elevation, ice application and immobilization. Review of the x-ray report dated 5/21/12 revealed a "New minimally displaced acute fracture at mid/distal shaft of the tibia" of the right leg. A tibia fracture is a break in the bone of the lower leg or shin bone. Review of the orthopedist report of consultation dated 5/22/12 revealed a long leg cast was applied on the right leg as treatment for the fracture. Review of the incident report dated 5/20/12 authored by Nurse#1 revealed "The CNAs (nursing assistant) came and got me and said theres [there] been an accident. They reported to	F 323	2. All residents have been assessed and evaluated by the Rehabilitation Manager/Coordinator to determine needs for transfer and mobility assistance on 6/14/12. She will continue to assess all residents on admission, quarterly and/or in the event of a change in their condition. Residents have been identified and interventions have been addressed by the Rehab Dept. & the Nursing Dept.to determine if a mechanical lift device is appropriate. All interventions have been implemented and documented in the residents' chart and care planned by the interdisciplinary care plan team. 3. The Admission Assessment Nurse assesses each resident's needs for transfers and mobility. The Nurse documents residents' transferring and lifting needs in the task care plan (kiosk). The individual care plan is reviewed and updated as transfer/mobility needs of the resident changes by MDS staff. Mechanical lift devices are available and utilized on each hall 24 hours a day. A new Hoyer Lift Daily Audit Form has been implemented on 6/14/12. cont'd →	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345024	A. BUILDING _____ B. WING _____	06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS NURSING CENTER INC	5229 APPOMATTOX ROAD PLEASANT GARDEN, NC 27313

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F 323	Continued From page 2 me that they were getting _____[Resident's name] in the bed and her foot got caught. She has a skin tear and says her ankle hurts." An interview on 6/13/12 at 3 p.m. with Nurse#1 via the phone revealed on 5/20/12 she was told by NA#3 and NA#4 that they were putting the resident back to bed and her foot got caught on the bedrail. The interview revealed that when they heard the resident scream they immediately repositioned her. Nurse#1 indicated the resident had a skin tear. "I called the NP and x-rays were done the next morning. I could not remember if there was a lift in the resident ' s room or in the hallway." An interview on 6/13/12 at 1:30 p.m. with Nurse#2 revealed NA#3, assigned to resident, called NA#4 from the hallway to assist her in transferring the resident. "The aides used a 2 person transfer instead of the ___(name of the mechanical lift)." Review of the typed statement dated 5/24/12 of NA#3 revealed she had told Nurse#1 that the incident occurred while transferring Resident#48 back to bed when "they actual did not use the _____(name of mechanical lift) but had it there as a deception." Unsuccessful attempts were made to contact NA#3 and NA#4. Observation of the resident on 6/14/12 at 8:30 a.m. revealed the resident was out of bed with a cast on her lower right leg. An interview on 6/13/12 at 2:10 p.m. with nursing assistant #1 (NA#1) who was assigned to care for the resident revealed Resident#48 required the	F 323	4. All CNAs currently working have been in-serviced on the proper use of mechanical lift devices by the Administrator and SDC beginning 5/22/12. All CNAs have reviewed the policy for safe lifting and performed a return demonstration using the lift prior to working their shift by the SDC 6/21-7/2-2012. CNAs on LOA, Medical leave or PRN status will be in-serviced prior to their tour of duty. Nursing staff is educated on proper mechanical lift devices during orientation and quarterly by the SDC. Each resident requiring a mechanical lift device for transfers is monitored to ensure effectiveness and consistency by their staff nurse daily. The Hoyer Lift Daily Audit Form is reviewed daily by the Nurse Manager and discussed during morning meeting. The QA nurse collects the data and evaluates to ensure compliance. This information is reported at the monthly QA meeting and will continue permanently.	

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	345024	A. BUILDING _____ B. WING _____	06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS NURSING CENTER INC	5229 APPOMATTOX ROAD PLEASANT GARDEN, NC 27313

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F 323	Continued From page 3 use of mechanical lift for transferring as far back as November 2011. NA#2 joined the interview and indicated that she was aware that the resident required a mechanical lift for transfers as far back as September 2011 An interview on 6/14/12 at 11 a.m. with the director of nurses (DON) revealed she was told by staff that Resident#48 had a skin tear and edema of the right ankle. The DON indicated she spoke to Nurse#1 who indicated she was told it happened during a transfer. The DON indicated she spoke with NA#4 over the phone who confirmed the incident happened during a ____(name of mechanical lift) transfer. During the interview the DON indicated that the information that she was hearing did not add up. Continued interview with the DON indicated the roommate of Resident#48 told the social worker that no lift was used to transfer the resident when this incident happened. Continued interview with the DON indicated she spoke with NA#4 for a second time and (NA#4) indicated a mechanical lift was not used. The DON revealed that NA#4 indicated to her that she was only helping NA#3 and did not know the resident required a mechanical lift for transfer. According to the interview with the DON, NA#4 was sent home for 2 days and retrained on the use of the _____(name of mechanical lift). The DON continued to indicate that she spoke with NA#3 on 5/23/12 or 5/24/12 initially who stated Resident#48's leg was injured during mechanical lift transfer. Then NA#3 admitted a mechanical lift was not used. During the interview the DON indicated NA#3 didn't think it was an issue not using a mechanical lift for a transfer. NA#3 knew from the Kiosk how to transfer the resident using	F 323		

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	345024	A. BUILDING _____ B. WING _____	06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS NURSING CENTER INC	5229 APPOMATTOX ROAD PLEASANT GARDEN, NC 27313

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F 323	Continued From page 4 a mechanical lift. Further interview with the DON indicated that NA#3 was not currently working in the facility and would not be returning to the facility. The DON indicated she spoke with NA#3 about being truthful, reporting the incident correctly and to follow the proper procedure in using the mechanical lift. The DON voiced that all staff that were on duty the week of 5/21/12 were in-serviced, the facility instituted the use of laminated signs for quick reference, discussed the incident in the stand up meeting and MDS nurse#1 and Staff Development Coordinator (SDC) conducted audits. An interview on 6/14/12 at 11:15 am with MDS nurse#1 revealed "only thing I did was repeat in-services to staff regarding pink colored and green colored signs that we would be implementing. I have not done an audit of the residents" regarding the incident involving Resident#48. MDS nurse#1 indicated when new orders come in for mechanical lifts, "I place the sign up." MDS nurse#1 indicated she "Don't do audits, just the signs." The SDC joined the conversation who indicated not all nursing staff had been in serviced as of 6/14/12. The in-services were a "Constant work in process." Continued interview with SDC indicated the next in-service would occur on 6/21/12 during the skills fair. SDC indicated that assistant director of nurses (ADON) and QA (quality assurance) coordinator did audits. An interview on 6/14/12 at 11:30 a.m. with the QA coordinator revealed she monitored the hall where the incident happened but these routine rounds were not documented as well as audits of	F 323		

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F 323	Continued From page 5 other residents that may be at risk during transferring using the mechanical lift device On 6/14/12 at 11:41 am, an interview with the ADON and DON revealed the audits were done by the DON, ADON, and MDS nurse#1, and Rehabilitation Director. On 6/14/12 at 11:42 am a joint meeting with the administrator, DON, and ADON was held. The DON revealed that Nurse#2, the ADON, Rehabilitation Coordinator and herself conducted audits but did not document the findings. The DON indicated she expected her staff to follow the orders and use the mechanical lift as required. During an interview on 6/14/12 at 11:50 AM, Nurse#2, indicated that she did not do a formalized audit of the incident regarding Resident#48 . Nurse #2 further stated that the audit process included verbal communication from shift to shift, nursing to observe staff during lift/transfers. However, she did not have a list of the staff that she had observed or any documentation. An interview on 6/14/12 at 11:45 p.m. with ADON revealed a form titled ___(name of mechanical lift) Lift Use-Place would be initiated today (6/14/12) to audit the use of the mechanical lifts.	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED
JUL 26 2012
CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345024	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS NURSING CENTER INC	5229 APPOMATTOX ROAD PLEASANT GARDEN, NC 27313

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 07/10/2012 the door to the soiled linen room at the laundry failed to close and latch. 42 CFR 483.70 (a)	K 029	K029 The door to the soiled linen room at the laundry has been repaired to close and latch properly by the maintenance department. All doors have been inspected to ensure they close and latch properly by the maintenance department. The maintenance department inspects doors weekly and repairs, if needed, are completed immediately to make certain doors close and latch properly by maintenance. The 'Inspection of Doors' checklist is completed by the maintenance person as he tests the door for compliance. Weekly maintenance rounds include the inspection of doors to ensure they close and latch properly. The (QA) 'Inspection of Doors' checklist is kept on a clipboard in the maintenance office and monitored by the Director weekly to ensure doors have been checked and function properly.	07/10/12

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

Mary Clapp Coleman — Administrator — 07/25/12

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