DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		TRUCTION	(X3) DATE SURVEY COMPLETED	
		345015	B. WING			04	/19/2017
NAME OF P	ROVIDER OR SUPPLIER		•	STREET	ADDRESS, CITY, STATE, ZIP CODE	•	
CLAPPS	CONVALESCENT NH						
				ASHEE	BORO, NC 27203		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157 SS=D	483.10(g)(14) NOTIF (INJURY/DECLINE/R		F 1	57			5/17/17
	(g)(14) Notification of	Changes.					
	consult with the resid	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is-					
		ving the resident which as the potential for requiring n;					
	mental, or psychosoc deterioration in health	n, mental, or psychosocial reatening conditions or					
	a need to discontinue	erse consequences, or to					
	(D) A decision to tran resident from the faci §483.15(c)(1)(ii).						
	(14)(i) of this section, all pertinent information	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the					
		also promptly notify the dent representative, if any,					
	(A) A change in room	or roommate assignment					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI	E	1	TITLE		(X6) DATE
Electroni	cally Signed						05/10/2017

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/19/2017 / APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345015	B. WING			04/	19/2017
NAME OF PR	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				50	00 MOUNTAIN TOP DRIVE		
CLAPPS C	ONVALESCENT NH			Α	SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 157	Continued From page as specified in §483.1		F	157			
		ent rights under Federal or ns as specified in paragraph					
	update the address (r phone number of the This REQUIREMENT by: Based on observation record review, the fac physician or the respo	ecord and periodically nailing and email) and resident representative(s). is not met as evidenced n, staff interviews and illity failed to notify the onsible party (RP) of a skin 141) of 2 residents reviewed			F157 1. Corrective actions taken for those residents found to have been affected	by	
	The findings included	:			the deficient practice: " On 4/20/17 Resident #141⊓s skir	-	
	long term anticoagula dated 1/12/17 indicate cognately intact and r assistance with bed n and toileting. He was with locomotion on an non-ambulatory in the	of diabetes, sepsis and nt use. His admission MDS ed Resident #141 was equired extensive nobility, transfers, dressing coded for limited assistance ad off the unit, and e hall but extensive			tear was examined by the Director of Nursing. The attending physician was notified of the skin tear by the Director Nursing and order for treatment was received. Accident/Incident report wa completed and the responsible party w notified on 4/20/17 of the skin tear by DON.	of s vas the	
	coded with no skin iss				 Residents having the potential to b affected by the same deficient practice were identified and the 		
	Resident #141 was ca daily living (ADL) assi 4/12/17.				following action taken: " All resident with skin tears were evaluated by the DON and Assistant Director of Nursing to ensure the Physician/resident/family were notified	l of	
		4/17/17 at 4:03 PM, dry gauze dressing to his stated he bumped it on his			the skin tear and any new treatment orders. Residents that were found to have had no documentation supportin	g	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN TOP DRIVE CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 157 Continued From page 2 F 157 bedside table. The dressing was clean and dry the family had been notified of new skin but there was no date as to when the dry dressing tear. All were found to have had the was applied. Resident #141 was unable to state physician notified and treatment started. when the dressing was last changed. ADON notified family members by In a review of the facility incident log from phone of those residents who were found October 2016 to present did not include any not to have documentation in place of new incidents involving Resident #141. skin A review of the Resident #141 's electronic Completed: 5/3/17 medical record included a Wound Assessment Report dated 4/11/17 that identified a skin tear to the left upper forearm. It was assessed as a new wound measuring 3.0 centimeter (cm) x 2.5 cm. 3. Measures or systemic changes put in The report completed by Nurse #6 indicated there place to ensure the corrective actions do was not treatment required. The physician and not reoccur: the responsible party were not documented as The DON and Administrator reviewed the having been notified. facility policy for Change in Resident Condition or Status to ensure all the In a telephone interview on 4/19/17 at 11:45 AM. requirements were met in the current Nurse #6 stated she thought the skin tear to policy relating to F157 regulation 483.10(b)(11) Notification of Changes. Resident #141 's left forearm happened over an existing area therefore she did not do incident The current facility policy does meet the requirement and was used for the report or notified the physician or RP. Nurse #6 stated she may have told Resident #141 ' s RP in-service education for the licensed when she came in since she was at the facility nurses. every day. In-Service training was initiated on A review of the undated policy titled Accidents 4/26/17 by the ADON for all nurses and Incidents Investigation read all incidents concerning requirements for immediate occurring to a resident must be reported and physician notification when an accident documented. The attending physician should be with injury to the resident occurs and has notified along with the resident RP. the potential for requiring physician intervention and notifying the responsible In an interview on 4/19/17 at 12:10 PM, the DON party of incidents and new Physician stated it was the expectation of the facility notify orders. All licensed nurses were required the physician for orders to treat a new skin tear to receive and acknowledge the Physician since there was no facility protocol for skin tears. notification in-service training prior to beginning his/her next scheduled work shift.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/19/201 FORM APPROVE OMB NO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345015	B. WING		04/19/2017
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
			5	00 MOUNTAIN TOP DRIVE	
CLAPPS	CONVALESCENT NH		A	ASHEBORO, NC 27203	
(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)	
F 157	Continued From page	e 3	F 157		
	as outlined by the con must- (ii) Be provided by qu accordance with each care. This REQUIREMENT by: Based on observatio	RE PLAN e Care Plans d or arranged by the facility, mprehensive care plan,	F 282	 4. How the corrective actions will be monitored to ensure the deficient practivity will not reoccur, i.e. quality assurance measures implemented: The Director of Nursing or the Assistant Director of Nursing will monitall Accidents/Incidents on a daily basis one week; weekly basis for 4 weeks; every 2 weeks for 30 days and the monthly for 3 months to assure compliance with the Change in Reside Condition or Status policy. The DON will take the audits to th QA Committee and results of that monitoring will be reviewed and discuss in the monthly QA Committee meeting The QA committee will assess and mothe action plan as needed to ensure continual compliance. Completed: 5/15/17 F282 Services by Qualified Persons/F Care Plan 	e for for for 5/17/17

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ___ 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 4 F 282 residents who required extensive assistance with 1. Corrective actions taken for those ADL (activities of daily living) care (Resident residents found to have been affected by #111). The findings included: the deficient practice: 1. Resident #111 was admitted to the facility On 4/18/17 The Director of Nursing 12/23/11. Cumulative diagnoses included instructed the Nursing Assistant to Alzheimer 's disease. complete nail care for Resident #111. A Quarterly Minimum Data Set (MDS) dated 2. Residents having the potential to be 3/2/17 indicated Resident #111 was severely affected by the same deficient practice impaired in cognition. Resident #111 required were identified and the extensive assistance of one person for personal following action taken: hygiene. Rejection of care was not indicated as On 4/18/17 DON evaluated all having occurred during the assessment period. Residents nails to ensure nail care had A care plan dated 3/7/17 indicated Resident #111 been provided and found all Resident s required extensive assistance with personal to have had appropriate nail care hygiene. Approaches included, in part, assist her delivered. with personal hygiene daily. Make sure hands and face are clean and hair is combed. 3. Measures or systemic changes put in On 4/17/17 at 3:30PM. Resident #111 was place to ensure the corrective actions do observed to have brown material under all of her not reoccur: fingernails on both hands. The DON and or Assistant Director of On 4/18/17 at 9:00AM, Resident #111 was Nursing will provide education to all observed lying in bed. She continued to have Licensed Nurses on checking and brown material under each nail on both hands. addressing nail care on weekly skin assessment. All Licensed Nurses will On 4/18/17 at 11:06AM, an observation revealed have received education prior to returning Resident #111 dressed and lying in bed. She to work. continued to have brown material under each nail The DON and or ADON will provide on both hands. education to all NA s on providing nail care during ADL care. On 4/18/17 at 2:42PM, an interview was Completed on: 5/17/17 conducted with NA #1. She stated she had provided care for Resident #111 on day shift. She 4. How the corrective actions will be said Resident #111 helped with putting on her monitored to ensure the deficient practice upper body clothing and washing her face and will not reoccur, i.e. quality assurance

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 312 Continued From page 9 F 312 services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: F312 ADL Care Provided for Dependent Based on observation, medical record review, resident and staff interviews, the facility failed to Resident provide nail care to one of one resident who required extensive assistance and/or and were 1. Corrective actions taken for those was dependent on staff for personal hygiene residents found to have been affected by (Resident #111). The findings included: the deficient practice: Resident #111 was admitted to the facility On 4/18/17 The Director of Nursing 12/23/11. Cumulative diagnoses included instructed the Nursing Assistant to Alzheimer 's disease. complete nail care for Resident #111. Follow up by DON found Resident #111 A Quarterly Minimum Data Set (MDS) dated nails to be clean. 3/2/17 indicated Resident #111 was severely impaired in cognition. Resident #111 required 2. Residents having the potential to be extensive assistance of one person for personal affected by the same deficient practice hygiene. Rejection of care was not indicated as were identified and the having occurred during the assessment period. following action taken: On 4/18/17 DON evaluated all A care plan dated 3/7/17 indicated Resident #111 required extensive assistance with personal Residents nails to ensure nail care had hygiene. Approaches included, in part to assist been provided and found all Resident s her with personal hygiene daily and make sure to have had appropriate nail care hands and face are clean and hair is combed. delivered. On 4/17/17 at 3:30 PM, Resident #111 was observed to have brown material under all of her 3. Measures or systemic changes put in fingernails on both hands. place to ensure the corrective actions do not reoccur: On 4/18/17 at 9:00 AM, Resident #111 was observed lying in bed. She continued to have The DON and or Assistant Director of brown material under each fingernail on both Nursing will provide education to all hands. Licensed Nurses on checking and addressing nail care on weekly skin On 4/18/17 at 11:06 AM, an observation revealed assessment. Resident #111 dressed and lying in bed. She The DON and or ADON will provide

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 312 Continued From page 10 F 312 continued to have brown material under each education to NA s on providing nail care fingernail on both hands. during ADL care. Completed on: 5/17/17 On 4/18/17 at 2:42 PM, an interview was 4. How the corrective actions will be conducted with NA #1. She stated she had provided care for Resident #111 on day shift. She monitored to ensure the deficient practice said Resident #111 helped with putting on her will not reoccur, i.e. guality assurance upper body clothing and washing her face and measures implemented: was dependent on staff for all other areas of care. NA #1 said morning care included making sure The Director of Nursing or the that Resident #111 's fingernails were clean. She Assistant Director of Nursing will monitor stated Resident #111 had times when she was 10 random residents on a daily basis for resistive to nail care. If that happened, she one week; weekly basis for 4 weeks; returned later and encouraged her to let staff every 2 weeks for 30 days and the clean her nails. NA #1 said Resident #111 had monthly for 3 months to assure resisted nail care this morning but she had not compliance. informed anyone and had not gotten a chance to The DON will take the audits to the tell the nurse. QA Committee and results of that monitoring will be reviewed and discussed Nursing notes were reviewed from March 1, 2017 in the monthly QA Committee meeting. through present. There was were no The QA committee will assess and modify documented episodes of resistance to care. the action plan as needed to ensure continual compliance On 4/18/17 at 3:37 PM, an observation of Completed on: 5/17/17 Resident #111 was conducted with the Director of Nursing. She stated she expected nursing staff to monitor, clean and inspect Resident #111 's fingernails daily during morning care, when giving a bath and on shower days. The Director of Nursing observed Resident #111 's fingernails and said the fingernails should have been cleaned and free from the dark material. When asked if she would let staff clean her nails, Resident #111 stated "Yes". On 4/19/17 at 10:40 AM, an observation of Resident #111 revealed all of her fingernails on both hands were trimmed and clean under every nail.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/19/2017 / APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345015	B. WING			04/	19/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CLAPPS (CONVALESCENT NH				00 MOUNTAIN TOP DRIVE SHEBORO, NC 27203		
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F 323 SS=D	483.25(d)(1)(2)(n)(1)- HAZARDS/SUPERVI	(3) FREE OF ACCIDENT SION/DEVICES	F	323			5/17/17
	(d) Accidents. The facility must ensu	ire that -					
	(1) The resident envir from accident hazards	onment remains as free s as is possible; and					
		eives adequate supervision es to prevent accidents.					
	appropriate alternative bed rail. If a bed or si must ensure correct in	ails, including but not limited					
	(1) Assess the resider from bed rails prior to	nt for risk of entrapment installation.					
		and benefits of bed rails with nt representative and obtain or to installation.					
		ed's dimensions are sident's size and weight. is not met as evidenced					
	record review, the fac monitor the safe conti standing lift for a resid during the use of the s	n, staff interviews and sility failed to evaluate and inued use of a mechanical dent who sustained a fall standing lift for a transfer for residents reviewed for			F323 1. Corrective actions taken for those residents found to have been affected the deficient practice. " 4/25/17 Physical Therapy re-evaluated Resident # 70 to confirm use of Stand Lift as safe means of transfer. The Stand Lift was determine	the	

Event ID: GX5O11

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 12 F 323 A review of the facilities ' policy dated 12/19/07 be an appropriate mechanical lift to be titled Mechanical Lift/+2 Assistance Transfer used for the residents I transfers to and Policy read the standing lift required the from surfaces. assistance of one staff member and the sling lift 2. Residents having the potential to be required 2 person assistance. affected by the same deficient practice Resident #70 was admitted 10/23/14 with were cumulative diagnoses of osteoporosis, scoliosis, identified and the following action taken: and a history of falls. All falls for the last month were Resident #70 's last documented Rehabilitation reviewed to determine if a therapy Screen was dated 2/27/17 which read she was referral/evaluation was necessary. No falls non-ambulatory and was to be transferred using due to mechanical lift were noted. the standing lift. Completed:5/5/17 The most recent quarterly Minimum Data Set (MDS) dated 3/1/17 indicated Resident #70 had Review of all residents requiring the moderate cognitive impairment with no behaviors. use of a mechanical lift will be completed She required extensive assistance with her by physical therapy to determine safe transfers to and from surfaces. transfers with two person assistance. She was coded as non-ambulatory and as having no falls. Completed:5/17/17 Resident #70 was care planned as a fall risk on 3. Measures or systemic changes put in 3/6/17 with interventions to include the notification place to ensure the corrective actions do of therapy for a fall and nonskid foot wear. She not was care planned for staff assistance with reoccur: transfers. The Director of Nursing and/or Assistant Director of Nursing will continue A review of the facility incident log from October to review incident/accident forms and 2016 to present included one fall recorded for document any new interventions/referrals Resident #70 on 3/18/17. etc. These entries will be dated and timed at the time of the initial incident report A review of the incident report dated 3/18/17 at review. The Fall Team Members will 11:35 AM specified Resident #70 was assisted to review the reports again weekly during the the ground from the standing lift. Resident #70 interdisciplinary fall team meeting. was assessed for injuries then was lifted from the The DON and/or the ADON will be ground and placed in her wheelchair using a sling notified immediately of a fall the occurring lift. Nurse #3 instructed the Nursing Assistant during the use of a mechanical lift. (NA) #2 to use the sling lift over the weekend until Physical Therapy will be notified

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 13 F 323 Resident #70 could be re-evaluated by therapy. immediately of a fall occurring during the The physician and responsible party were use of a mechanical lift. Therapy will notified. assess the resident within 24 hours of the fall to ensure the appropriate mechanical A review of the Fall Scene Investigation Report lift is being used. dated 3/18/17 indicated Resident #70 lost All falls will be discussed during daily strength and appeared to get weak. The fall was Department Meetings. Those in attendance will be; Administrator, Director intercepted during a transfer using the standing left. The report indicated Resident #70 was being of Nursing, Assistant Director of Nursing, put back into her wheelchair. The report Director of Social Services, Admission Director, Transition Care Nurse, MDS documented she was wearing slippers at the time of the fall and there was greater than 15 feet from Coordinators, Dietary Manager, Director the beauty shop chair to Resident #70 's of Physical/Occupational Therapy, wheelchair. Immediate interventions put in place Medical Record Manager, Human by Nurse #3 were to use a sling lift with two Resources Manager, Business Office person assistance for transfers for the rest of the Manager, Staff Coordinator, weekend and to ensure she was wearing gripper Environmental Services Manager, socks or shoes for transfers. Maintenance Manager. Fall meetings are currently scheduled A review of the Fall Team Members portion of the to occur weekly. The MDS Coordinator Fall Scene Investigation Report was not has been appointed to conduct/lead the completed until 4/6/17. It read Resident #70 was interdisciplinary meeting in the absence of the DON/ADON to assure the falls are lowered to the floor while in the standing lift. She could no longer stand. The sling lift was used to reviewed by the interdisciplinary at least assist her back to her wheelchair after being weekly. lowered to the floor. The plan was to monitor All Licensed nurses and Nursing Resident #70 during standing lift transfers. The Assistants will be in-serviced on the Director of Nursing (DON) and the Assistant therapy referral process listed above by Director of Nursing (ADON) signatures were on the DON and/or ADON. Resident #70 's Fall Members form but there was no member from the therapy department Completion Date: 5/17/17 documented as involved the Fall Team discussion on 4/6/17 of Resident #70 's fall that occurred on 4. How the corrective actions will be 3/18/17. The Fall Team discussion made no monitored to ensure the deficient practice documented mention of the foot wear used during will not reoccur, i.e. quality assurance measures the transfer or Nurse #3 's recommendation to use gripper socks during transfers. implemented: In a late entry nursing note dated Saturday The Administrator will audit all Fall

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 14 F 323 3/18/17 at 3:22 PM specified at 11:35 AM the Investigation Reports to assure the initial nurse was called to the beauty shop by the aide. review conducted by the DON and/or Resident #70 's legs slid out from under her ADON has been completed and while in the standing lift. Resident #70 was documented. The auditing will occur as assisted to the floor where she was assessed for follows: All reports weekly for 1 month, injuries. After no injuries determined. Resident then at least 5 per month for 3 months. #70 was assisted to her wheelchair using the The DON/ADON will monitor all falls mechanical sling lift. The immediate intervention involving a mechanical lift to assure a was the continued use of a sling lift until Resident therapy referral was initiated and an #70 could be re-evaluated by therapy. evaluation/screen completed. All falls weekly for 1 month, then at least 5 per In an interview on 4/18/17 at 3:57 PM, the month for 3 months. Occupational Therapist (OT) stated she QA Audit tools were developed to completed the transfer screen on Resident #70 record the results of the monitoring. The on 2/27/17. The OT stated she did not actually DON will take the audits to the QA observed a transfer using the standing lift nor did Committee and results of that monitoring she reassess Resident #70 's transfer ability will be reviewed and discussed in the using the standing lift after the fall on 3/18/17. monthly QA Committee meeting. The OT stated the Rehabilitation Director The QA committee will assess and attended weekly fall meetings with the Director of modify the action plan as needed to Nursing (DON) and the Assistant Director of ensure continual compliance the results of Nursing (ADON). The OT stated Resident #70 that monitoring will be reviewed and had a history of not participating in therapy. discussed in the monthly QA Committee meeting. The QA committee will assess In an interview on 4/18/17 at 5:00 PM, the DON and modify the action plan as needed to stated it was her expectation that therapy ensure continual compliance. evaluate Resident #70 's lift status at least quarterly or if there was a concern involving safe Completed:5/17/17 transfers. In an interview on 4/18/17 at 6:00 PM, Nurse #3 stated Resident #70 's personal beautician came in to do her hair. Two aides went to get Resident #70 from the beauty shop with the standing lift. NA #2 reported to Nurse #3 that Resident #70 's legs gave out from under her while she was in the lift from the beauty shop chair to her wheelchair. Nurse #3 stated NA #2 reported she and the beautician lowered Resident #70 to the floor.

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 05/19/2017 1 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345015	B. WING		_	04/	19/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CLAPPS	CONVALESCENT NH			500 MOUNTAIN TOP DRIV			
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F 323	Nurse #3 stated she i the sling lift to transfe back into her wheelch continue using the slin #3 stated Resident #7 shop chair prior to the recall who the other a she was not interview statement about the in #70 's fall Saturday 3 the incident report and In an observation on 4 and NA# 4 transferred standing lift from her y and placed Resident # #70 was wearing grip positioning from the w lift, Resident #70 appel lifted her feet to allow slide under her feet w her hands and graspe standing lift. The aide Resident #70 's waist hooked the sling onto #3 proceeded to raise observed to be unstea reminded Resident #7 standing. Resident #7 full upright posture du scoliosis. In an interview with N NA #4 stated she had five years. She stated was to be lifted with a initially admitted but s	esident #70 for injuries and nstructed the NA #2 to use r Resident #70 off the floor air. Nurse #3 told NA #2 to ng lift until Monday. Nurse '0 was sitting in the beauty e transfer and she did not ide was. Nurse #3 stated ed or asked to write a ncident involving Resident /18/17. But she completed d wrote a nursing note. 4/18/17 at 6:52 PM, NA #3 d Resident #70 using the wheelchair to the bathroom #70 on the toilet. Resident per socks. During the vheelchair unto the standing eared cooperative. She to the base of the lift to hile she reached out with ed the handles on the s applied the sling around t under her arms then the handles of the lift. NA e the lift. Resident #70 was ady on her feet while NA #4 70 to lock her knees while '0 was unable to maintain a	F 32				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
		345015	B. WING		04/19/2	2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CLAPPS	CONVALESCENT NH			500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203			
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CO	(X5) DMPLETIO DATE	
F 323	any problems with Ret the standing lift. She is recommendation of re- reviewing a lift recom- stations that was peri stated one staff memi- standing lift and they how to lift a resident if was unsafe. NA #3 a not aware that any ch- be reported to a nurse In an interview on 4/1 confirmed she was in 3/18/17 and stated sh for twenty-four years. Resident #70 out of th her legs gave out. NA was wearing gripper s memory. NA #2 state buckled under her an to the floor with the as personal beautician. S aide present and she and assess Resident She stated Resident ap ain anywhere. After Resident #70, she go and used the sling lift from off the floor back was unable to recall w assisted her but Nurs the sling lift until thera #70 's lift safety. NA what day it was that fe #70 complained about	esident #70 and the use of stated she followed the esident lift status by mendation list at the nursing odically updated. NA #4 ber could perform a could use their discretion on f they felt the way indicated and NA #4 stated they were hange in a lift status should e. 9/17 at 8:55 AM, NA #2 volved in the incident on he had worked at the facility NA #2 recalled assisting he beauty shop chair when A #2 stated Resident #70 socks to the best of her ed Resident #70 ' s knees d she eased Resident #70 softs to the best of her ed Resident #70 ' s knees d she eased Resident #70 softs to the best of her ed Resident #70 ' s knees d she eased Resident #70 softs to the best of her ed to perform the incident on the stated she was the only left to get Nurse #3 to come #70 before she was moved. #70 did not complaint of any ' Nurse #3 assessed t another aide to help her to transfer Resident #70 k into her wheelchair. NA #2 who the other aide was that e #3 told the aides to use apy could assess Resident #2 stated she was not sure ollowing week, but Resident it using the sling lift and said NA #2 stated she asked	F 32	23			

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ICAID SERVICES					1 APPROVED . 0938-0391	
PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED		
345015	B. WING		_	04/19/2017		
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		ASHEBORO, NC 27203				
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	345015 NT OF DEFICIENCIES THE PRECEDED BY FULL ENTIFYING INFORMATION) NA #2 stated she did asferring Resident #70 that. NA #2 stated she ver re-evaluated tus after the fall on was never interviewed ent about the fall that (17. at 9:03 AM, Nurse #5 A #2 coming to her but on as needed to lift she did not recall dent #70 ' s lift status 9/17 at 9:34 AM, the e to provide any of the standing lift for all meeting on 4/6/17. at 10:00 AM, the (M) stated she was part She stated the fall for every Thursday. o fall meeting on use the DON and the or the meeting. The all meeting on 4/6/17 sident #70. The RM day and on 4/6/17, the had to leave before g portion of the Fall RM stated she did not #70 ' s fall until the M stated if a fall al lift, it would be her	DENTIFICATION NUMBER: A. BUILDING 345015 B. WING NT OF DEFICIENCIES ID PREFIX TAG NT OF DEFICIENCIES ID PREFIX TAG NA #2 stated she did Insferring Resident #70 that. NA #2 stated she ver re-evaluated tus after the fall on was never interviewed int about the fall that /17. at 9:03 AM, Nurse #5 A#2 coming to her but on as needed to lift she did not recall dent #70 's lift status 9/17 at 9:34 AM, the e to provide any of the standing lift for all meeting on 4/6/17. at 10:00 AM, the M) stated she was part She stated the fall or every Thursday. o fall meeting on 4/6/17. sident #70. The RM day and on 4/6/17, the had to leave before g portion of the Fall RM stated she did not #70 's fall until the A stated if a fall al lift, it would	Jentification NUMBER: A. BUILDING 345015 B. WING Street Address, City, St Stated Ste Street Address, City, St State State Ste State S	Jentrelication NUMBER: A. BUILDING 345015 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE S00 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203 STREET ADDRESS, CITY, STATE, ZIP CODE S00 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203 NT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION INT IFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BI INTEGRATION ID PROVIDER'S PLAN OF CORRECTION INTEGRATION ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BI INTEGRATION ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BI INTEGRATION ID PROVIDER'S PLAN OF CORRECTION INTEGRATION ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BI INTEGRATION ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BI INTEGRATION ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BI INTEGRATION ID PROVIDER'S PLAN OF CORRECTION INTEGRATION ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BI INTERCATION ID PROVIDER'S PLAN OF CORRECTION THE APPROPRIATION THE APPROPRIATION THE APPROPRIATION TO ANDRESTICATION THE APPROPRIATION TO ANDRESTICATION THE APPROPRIATION TO ANDRESTICATION THE APPROPR	J45015 A. BUILDING COMP J45015 B. WING 04/ STREET ADDRESS, CITY, STATE, ZIP CODE S00 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203 TO OF DEFICIENCIES TE E PRECEDED BY FULL TAG PRETRY TAG FOUNDERST PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE UNTERVING INFORMATION) F 323 NA #2 stated she did Insferring Resident #70 that. NA #2 stated she ver re-evaluated Usa after the fall on was never interviewed int about the fall that (17. at 9:03 AM, Nurse #5 X#2 coming to her but on as needed to lift she did not traffit she did not call ident #70 's lift status 9/17 at 9:34 AM, the e to provide any of the standing lift for ill meeting on use the DON and the or the meeting. The all meeting on use the DON and the or the meeting. The all meeting on use the DON and the or the meeting. The all meeting on use the DON and the or the meeting. The all meeting on of the Fall RM stated she did that fall that	

Facility ID: 923103

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/19/2017 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345015	B. WING			04	/19/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPPS (CONVALESCENT NH				500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203		
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F 323	the staff necessarily p The RM stated if there nursing staff about a r there were rehabilitati at both nursing station complete the rehabilit In an interview on 4/1 nurse stated she care 3/6/17 that therapy be involving Resident #7 the facility had a com allowed for rapid notif accidents or changes notified all the departr interventions or notific timely. The MDS nurs report was generated generated a notification managers including th an incident. She state therapy to have re-ev had any new interven would have been care fall meeting. In a second interview RM confirmed she did from the facility comp regarding the fall that #70. She stated she v on Monday 3/20/17 w The RM also confirme expand and investiga from her computer wit written therapy referra	expectation that therapy be performing the evaluation. e was a concern from the resident ' s functional status, on referral forms available as and anyone could ation referral form. 9/17 at 11:30 AM, the MDS e planned the intervention on a notified for any falls 0. The MDS nurse stated puter compliance center that ication of any incidents, in a resident. The computer ment managers so cation could be completed as stated when the incident on 3/18/17, the computer on to all the department herapy that there had been ed she would have expected aluated the lift status and tions been initiated, they e planned during the weekly on 4/19/17 at 12:28 PM, the d receive a computer prompt liance center program occurred involving Resident vould have seen the prompt then she returned to work. ed she had the ability to te the nature of the incident thout having to be given a	F	323			
		11 4/19/17 at 12.33 PWI, the					

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ATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVE	8-039 EY
d plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
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F 323	Continued From page	e 19	F 32	3		
		were no fall meetings on				
		ecause she and ADON were				
		reasons. The DON stated dimmediately to determine if				
		eded. The DON confirmed				
	it was the practice of	the facility that the computer				
		as primarily used for falls to				
		terventions needed since				
		us with possibility of injury. e staff asking about using				
		sident #70 on 3/20/17				
		0 was afraid of the sling lift.				
		was uncertain if therapy				
		a safe transfer using the				
	-	ed it was her expectation				
		a mechanical device be t safety but it was the facility				
		ot an actual fall but Resident				
		the ground. The DON				
		el Resident #70 was wearing				
		d that slippers could be				
F 329	considered a safe for $483.45(d)(e)(1)(2)$	RUG REGIMEN IS FREE	F 32		5/17/	/17
F 329 SS=D	FROM UNNECESSA		F 32			17
	483.45(d) Unnecessa	ary Drugs-General.				
	Each resident's drug	regimen must be free from				
		An unnecessary drug is any				
	drug when used					
	(1) In excessive dose therapy); or	(including duplicate drug				
	(2) For excessive dur	ation; or				
	(3) Without adequate	monitoring; or				

Event ID: GX5O11

Facility ID: 923103

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/19/2017 APPROVED). 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345015	B. WING			04/19/2017		
NAME OF PF	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE			
CLAPPS C	ONVALESCENT NH			500	0 MOUNTAIN TOP DRIVE			
				AS	SHEBORO, NC 27203			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 329	Continued From page	20	F 3	29				
		adverse consequences se should be reduced or						
	· · ·	of the reasons stated in ough (5) of this section.						
	483.45(e) Psychotrop Based on a comprehe resident, the facility m	ensive assessment of a						
	drugs are not given th medication is necessa	-						
	gradual dose reduction interventions, unless of an effort to discontinu This REQUIREMENT by: Based on record revi physician interview, the physician signed Note Physician/Prescriber to regarding a follow up	clinically contraindicated, in e these drugs; is not met as evidenced ew, staff interview, and he facility failed to follow the e to Attending from the pharmacist			F329 Drug Regimen is Free of Unnecessary Drugs 1. Corrective actions taken for those residents found to have been affected the deficient practice.	by		
	Findings included: Record review reveale admitted to the facility most recent Minimum	on 3/3/04. The resident's			" On 4/20/17 THS level was obtained on resident # 23. and physician notifier results TSH 5.45 via phone by the Assistant Director on Nursing. Order received to increase Synthroid to 175	d of		

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 329 Continued From page 21 F 329 assessment was a quarterly assessment with an daily. Assessment Reference Date (ARD) of 3/9/17. On 4/23/17 The RN who processed the pharmacy note was re-educated by The MDS indicated the resident's cognition was severely impaired with short and long term the ADON on proper completion of the memory loss. The resident was coded with Physician Order on the Note to Attending abnormal behaviors and requiring extensive staff Physician/Prescriber form. assistance to being totally dependent on staff for all activities of daily living. The resident's coded 2. Residents having the potential to be diagnoses included hypothyroidism (underactive affected by the same deficient practice thyroid gland). were identified and the following action Resident #23's most recent TSH level lab was taken: drawn on 11/9/16. The TSH level on the lab All Pharmacy recommendations for report was 22.07 (The normal range is 0.350 to the last month were reviewed by the 4.500. A high TSH level confirms hypothyroidism). ADON to determine if recommendations A note on the reports indicated the resident's had been addressed by the Physician and current levothyroxine dose was 125 micrograms orders written when applicable (change in (mcg) daily. An additional note written on the lab medication/treatment). report and signed by the physician indicated an Completed on: 4/28/17 increase of the levothyroxine medication dose to 150 mcg every morning. The physician 3. Measures or systemic changes put in recommendation was documented as noted and place to ensure the corrective actions do transcribed on 11/10/16. not reoccur: A review of Resident #23's pharmacist The ADON will review all Notes to recommendations revealed a Note To the Attending Physician/Prescriber form Attending Physician/Prescriber, from the issued by Pharmacy Consultant and pharmacist dated 12/5/16. The pharmacist noted transcribe any orders instructed by the the resident's levothyroxine dose had been Physician/Practitioner. The ADON will increased to 150 mcg daily on 11/10/16. The indicate on the Note to Attending pharmacist's note further read the pharmacist did Physician Form if orders were written, and not find a follow up lab had been ordered to the date. check thyroid hormone levels. The pharmacist The DON will receive copies of the written inquiry to the physician was when would orders and review them for accuracy. the physician like a follow-up TSH completed? Pharmacy will review monthly the The pharmacist further expanded the resident Note to Attending Physician/Prescriber had been refusing medications, if the TSH result form for completion of recommendations was abnormal, the pharmacist asked the made and notify the DON and/or ADON in physician to look into the frequency of refusal of person on the day the pharmacy reviewed

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 329 Continued From page 22 F 329 the levothyroxine. The physician checked he had the record of any incomplete orders. agreed with the pharmacist's recommendation and signed the note. The note was stamped Completed:5/17/17 "FAXED" indicating the lab had been faxed on the date of 12/18/16 and a Registered Nurse (RN) wrote below the stamp mark "Noted no new 4. How the corrective actions will be orders" and was signed by the RN. monitored to ensure the deficient practice will A review was completed of the medical record of not reoccur, i.e. quality assurance Resident #23. No TSH lab results were noted in measures implemented: the medical record since 11/19/16. The DON will monitor 10 Note to An interview completed with the Director of Attending Physician/Prescriber forms Nursing (DON) on 4/18/17 at 4:12 PM revealed where the Physician/Practitioner has when a pharmacist had made a recommendation approved an order change to assure the on a Note To Attending Physician/Prescriber and order was written/transcribed correctly. a physician had signed and checked agreed, the This will be done every week for 4 weeks, order would have been noted by the nurse. The then taper to monthly for 2 months. QA DON reviewed Resident #23's Note to the Audit tools were developed to record the Attending Physician/Prescriber dated 12/5/16 and results of the monitoring. acknowledged the nurse had written there were Completed: 5/17/17 no new orders. The DON reviewed the Pharmacy will perform a monthly recommendation from the pharmacist to the physician regarding the TSH level and review of the previous month s acknowledged the physician had agreed with the recommendations for completion of recommendation and signed the document. The recommendations made and notify the DON stated her expectation was the nurse should DON and ADON of any incomplete orders have written a new order for the TSH lab. The DON will take the audits to the QA Committee and results of that A phone interview was conducted with Resident monitoring will be reviewed and discussed #23's physician on 4/19/17 at 10:58 AM. The in the monthly QA Committee meeting. physician stated he had signed the Note To The QA committee will assess and modify Attending Physician/Prescriber and agreed a TSH the action plan as needed to ensure lab should have been completed. The physician continual compliance further clarified it was his expectation due to having signed off on the Note To Attending Completed:5/17/17 Physician/Prescriber a lab had been recommended such as the TSH lab should have been ordered and completed.

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/19/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	
		345015	B. WING		_	04/	19/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CLAPPS (CONVALESCENT NH			00 MOUNTAIN TOP DRIVE	E		
			A	SHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page	23	F 329				
F 428 SS=D	 was her expectation if Pharmacy Note To Att for any recommendati had agreed upon and TSH if the T4 is low, a confirm that the thyroi gland) is responsible if T4 level is low and TS pituitary gland is more the hypothyroidism. 483.45(c)(1)(3)-(5) DF REPORT IRREGULA c) Drug Regimen Rev (1) The drug regimen reviewed at least onco- pharmacist. (3) A psychotropic dru- brain activities associa and behavior. These limited to, drugs in the (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist m to the attending physi 	 A 1:22 PM revealed it the nursing staff review the tending Physician/Prescriber ions the resident's physician signed off on. a high TSH level would id gland (not the pituitary for the hypothyroidism. If the SH is not elevated, the e likely to be the cause for RUG REGIMEN REVIEW, R, ACT ON riew of each resident must be e a month by a licensed ug is any drug that affects ated with mental processes drugs include, but are not e following categories: 	F 428				5/17/17

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/19/2017 / APPROVED). 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345015	B. WING			04/	19/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				50	00 MOUNTAIN TOP DRIVE		
CLAPPS C	ONVALESCENT NH			Α	SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From page	24	F	428			
		e, but are not limited to, any riteria set forth in paragraph an unnecessary drug.					
	during this review must separate, written report attending physician and director and director of minimum, the residen	noted by the pharmacist st be documented on a brt that is sent to the nd the facility's medical of nursing and lists, at a t's name, the relevant drug, e pharmacist identified.					
	resident's medical rec irregularity has been r action has been taken be no change in the n	reviewed and what, if any, n to address it. If there is to nedication, the attending ument his or her rationale in					
	and procedures for the review that include, but frames for the different steps the pharmacist identifies an irregularit to protect the resident	evelop and maintain policies e monthly drug regimen ut are not limited to, time nt steps in the process and must take when he or she ty that requires urgent action t. is not met as evidenced					
	Based on record revi facility failed to provid the continuation of me pharmacy recommend	dations for 2 of 5 residents sary drug review (Resident			F428 Drug Review1. Corrective actions taken for those residents found to have been affected the deficient practice.	l by	
	The findings included Resident #188 was ad	: dmitted to the facility on			" On 4/20/17 the physician for resident of the physician for resident and #23 was re-educated by the Assistant Director of Nursing on CMS	;	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 428 Continued From page 25 F 428 10/15/16 with diagnoses that included right hip guidelines requiring a reason be given for pain, anemia, Alzheimer's and dementia. The declining a dose reduction request from a pharmacy review most recent Minimum Data Set (MDS) assessment dated 1/19/17 revealed Resident On 4/26/17 the ADON contacted the #188 was severely cognitively impaired as physician asking him to give a reason for evidenced by a brief interview for mental status denial of a GDR requested by the (BIMS) score of 1. pharmacist on residents #188 and # 23. On 4/27/17 the Physician responded Review of Resident 188 care plan dated 1/24/17 to the ADON s request for resident #188 revealed a problem of, "Psychotropic drug use and #23. related to new order for citalopram and Xanax. The goals stated 1) Xanax will be effective for 2. Residents having the potential to be anxiety with no side effects x 90 days 2) Celexa affected by the same deficient practice will be effective for depression with no side were effects x 90 days. The approaches included; identified and the following action medication review monthly with recommendations taken: sent to medical doctor, monitor mood, behavior All Pharmacy recommendations for and cognitive status. the last month were reviewed by the ADON to determine if recommendations Review of "note to attending physician/prescriber" had been addressed by the Physician and from the outside pharmacy dated 3/1/17 stated, orders written for those found incomplete. "would a gradual dose reduction (GDR) be Completed on: 4/28/17 appropriate for either order? If not please give a reason for risk vs benefit. Thanks". The note 3. Measures or systemic changes put in revealed the following medications: Xanax 0.25 place to ensure the corrective actions do milligrams (mg) 1 every 8 hours as needed (PRN) not 10/16/16), Celexa 10mg every night (qhs) (11/16, reoccur: depression/anxiety), and Sonata 10mg qhs PRN The ADON will review all Notes to sleep (12/16, sleep). The physician/prescriber Attending Physician/Prescriber form response revealed "other". The note contained no issued by Pharmacy Consultant for the reason for the continuation of the medications. physician s response to the request for a The report indicated it was faxed and signed by GDR. The ADON will contact the the physician with no date identified. On 3/19/17 physician by fax for any pharmacy request the report identified it was faxed and stated no that do not state a reason for denial of new orders by a registered nurse. GDR made by the pharmacists. The ADON will follow up by phone in 7 Interview with the Assistant Director of Nursing days if no response has been received (ADON) on 4/18/17 at 4:00pm revealed the regarding request. medical doctor was aware that the pharmacist The DON will receive copies of the

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 428 Continued From page 26 F 428 needed a reason why the GDR (gradual dose request to review them for accuracy. reduction) was not wanted. He was made aware Pharmacy will review monthly the in March 2017 following a meeting with the Note to Attending Physician/Prescriber pharmacist in regards to the request not having a form for completion of recommendations reason for "disagree" or "other". The ADON made and notify the DON and ADON of continued with she did find other residents any incomplete orders. pharmacy request to have "other" and "disagree" Completed: 5/17/17 checked with no response. She stated that when there was missing reason as to why the physician checked "other" or "disagree" she had to contact 4. How the corrective actions will be the physician and clarify his reasoning for the monitored to ensure the deficient practice pharmacist. will not reoccur, i.e. quality assurance Interview with the Director of Nursing (DON) on measures implemented: 4/19/17 at 9:47am revealed it was her expectation that the physician included a reason The DON will monitor 10 Note to in the instance he disagreed or identified other on Attending Physician/Prescriber forms the notification form. She stated that in the where request for GRD have been made instance the physician did not include a reason by the pharmacy to assure request for the ADON would contact the physician to clarify GDR s have been addressed by the physician. This will be done every week the reason why he disagreed. for 4 weeks, then taper to monthly for 2 Interview with the Pharmacist on 4/19/17 at months. QA Audit tools were developed 9:07am reveled in the instance she did not have a to record the results of the monitoring. physician response for the reasoning as to why Pharmacy will perform a monthly he chose "disagree" or "other" she would note review of the previous month s that she needed a reason the following month. recommendations for completion of She further revealed that she normally talked with recommendations made and notify the the DON or ADON if she couldn't locate a reason DON and ADON of any incomplete orders for pharmacy recommended GDR. She revealed The DON will take the audits to the in March 2017 she had a discussion with the QA Committee and results of that ADON in regards to lack of physician monitoring will be reviewed and discussed documentation when pharmacy in the monthly QA Committee meeting. recommendations were declined. The The QA committee will assess and modify expectation is that the physician document the action plan as needed to ensure reason for "disagree" or "other" on the form. continual compliance. Completed: 5/17/17 Interview with the Physician on 4/19/17 at 10:57am indicated that he did not necessarily put

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923103

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/19/2017 / APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE	
		345015	B. WING			04/19/2017		
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CLAPPS CONVALESCENT NH					00 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 428	the pharmacy recommendations reason for not red to the potential of resident is reason for not red to the potential of resident if the stated the he rece when the pharmacy re- identified he for the age checked. 2. Record review rev admitted to the facility most recent Minimum assessment was code assessment was code assessment with an A (ARD) of 3/9/17. The resident's cognition w short and long term me was coded with abnor- extensive assistance on staff for all activities resident's coded diag non-alzheimer's deme resident's recorded me antidepressant and a A review of Resident is Administration Record ordered citalopram 20 to be given orally eve on 1/31/15 to be given hours as needed. A review of Resident is recommendations rev Attending Physician/F pharmacist, with a pri faxed date of 9/18/16 resident was ordered	ntinuation of medication on nendation report. He stated ucing medications was due ident's behaviors increasing. Eved a call from the ADON equired clarification when he gree, disagree or other was ealed Resident #23 was y on 3/3/04. The resident's n Data Set (MDS) ed as a quarterly Assessment Reference Date MDS indicated the vas severely impaired with nemory loss. The resident rmal behaviors and requiring to being totally dependent es of daily living. The noses included: entia and depression. The nedications included an diuretic. #23's April 2017 Medication d revealed the resident was 0 milligrams (mg) on 4/8/15 ry day and lorazepam 1 mg n intramuscular (IM) every 4 #23's pharmacist yealed a Note To the	F	428				

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	-	D HUMAN SERVICES				FORM	APPROVED		
STATEMENT C	S FOR MEDICARE & I of Deficiencies CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	D: 05/19/2017 M APPROVED <u>O. 0938-0391</u> E SURVEY PLETED //19/2017 COMPLETION DATE		
		345015	B. WING		_	04/19/2017			
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE				
CLAPPS C	ONVALESCENT NH		5	00 MOUNTAIN TOP DRIV	E				
			4	ASHEBORO, NC 27203	3				
(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 B NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION		
F 428	duplicative therapy. T physician intended to to please provide a re benefit for the continu The physician checke disagreed with the ph but provided no docur for checking the disag stamped "FAXED" inc faxed on the date of 9 Nurse (RN) wrote belo no changes" and was A Note To the Attendir regarding Resident #2 dated 1/4/17 was revi inquired to the physici Reduction (GDR) wou resident due to her re milligrams (mg) order every day for depress intramuscularly every agitation. The pharma physician checked the	ons) it may be viewed as The note further stated if the continue both medications eason for the risk versus the led use of both medications. ed the box indicating he armacist, signed the note, mentation as to the reason gree box. The note was dicating the note had been 0/18/16 and a Registered low the stamp mark "Noted signed by the RN. mg Physician/Prescriber 23, from the pharmacist, ewed. The pharmacist, ewed. The pharmacist ian if a Gradual Dose uld be appropriate for the ceiving citalopram 20 ed 4/8/14 to be given orally ion and lorazepam 1 mg four hours as needed for acist further noted, if the o pursue a GDR to please isk versus benefit. The e box indicating he	F 428		DEFICIENCY)				
	but provided no docur for checking the disag stamped "FAXED" inc faxed on the date of 2 Nurse (RN) wrote belo no changes" and was Another Note To the A Physician/Prescriber of	Attending regarding Resident #23,							
		dated 3/2/17 was reviewed. nunicated to the physician							

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	-	D HUMAN SERVICES				FORM	0: 05/19/2017 APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _			(X3) DATE COMP	
		345015	B. WING		_	04/	19/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
	CONVALESCENT NH		5	00 MOUNTAIN TOP DRIVE	E		
OLAITO			A	SHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	Medicare and Medica require the facility to a provide the reason for reduction on 2/19/17. the physician commen- reason for declining th the pharmacist wrote GIVE A REASON FOI OF THE GDR FOR [b CITALOPRAM] OR [b LORAZEPAM]. THAN checked the box indic pharmacist, signed th documentation as to t disagree box. The no- indicating the lab had 3/19/17 and a Register below the stamp mark was signed by the RN An interview with the 19:07 AM revealed she response for the reaso physician chose "disa pharmacist stated she needed a response an month. She further re- talked with the DON (ADON (Assistant Dire couldn't locate a reasor recommended GDR. 2017 she had a discu regards to lack of phy pharmacy recommend expectation was that the reason for "disagree"	id regulatory agencies ask you for and you to r declining the dose The note further requested int on the note regarding the ne dose reduction. Lastly, the following, "PLEASE R THE 2/19/17 DECLINE arand name for rand name for NK YOU." The physician tating he disagreed with the e note, but provided no he reason for checking the ate was stamped "FAXED" been faxed on the date of ered Nurse (RN) wrote k "Noted no changes" and l. Pharmacist on 4/19/17 at e did not have a physician oning as to why the gree" or "other." The e would document that she nd reason for the following evealed that she normally Director of Nursing) or the ector of Nursing) if she	F 428				

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CENTERS FOR MEDICARE & MEDICAID SERV	/ICES			(APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUP IDENTIFICATION	PLIER/CLIA (. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
345	015	B. WING		-	04/	19/2017
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
CLAPPS CONVALESCENT NH			00 MOUNTAIN TOP DRIVE SHEBORO, NC 27203			
(X4) ID SUMMARY STATEMENT OF DEFICIE PREFIX (EACH DEFICIENCY MUST BE PRECEDE TAG REGULATORY OR LSC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
 F 428 Continued From page 30 reason for the continuation of medicati pharmacy recommendation report. He reason for not reducing medications w the potential of resident's inappropriate increasing. An interview was conducted with the fa Administrator on 04/19/17 at 1:22 PM is administrator stated it was her expecta be documentation from the physician in medical record regarding the Gradual Reduction (GDR) recommendations m pharmacist. F 441 483.80(a)(1)(2)(4)(e)(f) INFECTION CO PREVENT SPREAD, LINENS (a) Infection prevention and control proc The facility must establish an infection and control program (IPCP) that must a minimum, the following elements: (1) A system for preventing, identifying investigating, and controlling infectiones communicable diseases for all residen volunteers, visitors, and other individua providing services under a contractual arrangement based upon the facility as conducted according to §483.70(e) an accepted national standards (facility as implementation is Phase 2); (2) Written standards, policies, and pro- for the program, which must include, b limited to: (i) A system of surveillance designed to possible communicable diseases or in 	e stated his as due to e behaviors acility and the tition there in the Dose ade by the ONTROL, ogram. prevention include, at include, at include, at sessment d following sessment ocedures ut are not	F 428				5/17/17

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/19/2017 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		(X3) DATE	
		345015	B. WING			04/19/2017		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD	E		
CLAPPS (CONVALESCENT NH				00 MOUNTAIN TOP DRIVE SHEBORO, NC 27203			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 441	Continued From page before they can sprea facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran to be followed to prev (iv) When and how iso resident; including but (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possific circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi) The hand hygiene by staff involved in dir (4) A system for recor under the facility's IPO	 31 d to other persons in the n possible incidents of e or infections should be smission-based precautions ent spread of infections; blation should be used for a tot limited to: at not limited to: at not limited to: at the isolation should be the ble for the resident under the a under which the facility bes with a communicable in lesions from direct or their food, if direct he disease; and c procedures to be followed ect resident contact. ding incidents identified CP and the corrective 		441				
	spread of infection.	-						

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 441 Continued From page 32 F 441 annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: F441 Based on observation, staff interview, manufacturer's specifications and facility policy. 1. Corrective actions taken for those the facility failed to follow manufacturer's residents found to have been affected by specifications for effective use of germicidal the deficient practice. wipes used for the disinfection of the alucometer Nurse # 1, 2 and 4 were educated on between residents for four of four residents the appropriate sanitizing and cleaning of (Resident #282, #219, #172, #160 and #118). glucometers by the Director of Nursing on The findings included: 4/18/17. The DON issued an individual glucometer to Residents # 282 #219, The Centers for Disease Control and Prevention #172, #160, #118 on 4/21/17. (CDC) Summary statement on Infection Prevention during Blood Glucose Monitoring and 2. Residents having the potential to be Insulin Administration reports, in part: "The affected by the same deficient practice Centers for Disease Control and Prevention were (CDC) has become increasingly concerned about identified and the following action the risks for transmitting hepatitis B virus (HBV) taken: and other infectious diseases during assisted A list of all residents with orders for blood glucose monitoring and insulin finger stick blood sugar testing was made administration ... Whenever possible, blood by the DON. These residents were glucose meters should not be shared. If they issued an individual glucometer on must be shared, the device should be cleaned 4/21/17 by the DON and disinfected after every use, per Completed on 4/21/17 manufacturer's instructions." 3. Measures or systemic changes put in place to ensure the corrective actions do Recommendations for Cleaning and Disinfection not of Glucometers North Carolina Statewide reoccur: Program for Infection control and Epidemiology On 4/22/17 all resident s requiring (SPICE) state, in part, "2. If no visible organic finger stick blood sugar testing were material is present, disinfect after each use the issued an individual glucometer exterior surfaces following the manufacturer's eliminating the need to share directions using a cloth/wipe with either an EPA glucometers. registered detergent/germicide with a In the event, a glucometer should be tuberculocidal or HBV (hepatitis B virus)/ HIV shared amongst residents all nurses (human immunodeficiency virus) label claim, or a were educated regarding the appropriate dilute bleach solution of 1:10 (one part bleach to sanitizing process of glucometers

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923103

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 33 F 441 F 441 9 parts water) to 1:100 concentration." between use by the Assistant Director of Nursing A facility policy, undated, stated "Glucometers are Completed on 4/28/26 to be cleaned and disinfected with a 4. How the corrective actions will be monitored to ensure the deficient practice EPA-registered detergent/ germicide with a tuberculocidal or HBV/HIV label claim. or a dilute will not bleach solution of 1:10 (one part bleach to 9 parts reoccur, i.e. quality assurance measures water) to 1:100 concentration, Glucometers are implemented: to be cleaned between each patient use." The DON and/or ADON will monitor nurses on all shifts performing finger stick 1. On 4/18/17 at 8:00PM, Nurse #1 was blood sugars to assure an individual observed obtaining Resident #282's blood sugar. assigned glucometer is used for testing. Nurse #1 wiped the glucometer with a germicidal The auditing will occur as follows: All wipe for 10 seconds, obtained Resident #282's nurse monitored weekly for two weeks, blood sugar, cleaned the glucometer with another then every other week for one month, germicidal wipe for 10 seconds and placed the then monthly for 3 months. glucometer in the basket. The DON and/or ADON will observe all Licensed Nurses clean a glucometer. A review of Manufacturer's instructions for the The auditing will occur as follows: All germicidal wipes stated, in part, to disinfect, use a nurse monitored weekly for two weeks, wipe to remove heavy soil. Unfold a clean wipe then every other week for one month, and thoroughly wet surface. Treated surface then monthly for 3 months. must remain visibly wet for a full 3 minutes. Use The DON will take the audits to the additional wipes if needed to assure continuous QA Committee and results of that three minutes wet contact time. monitoring will be reviewed and discussed in the monthly QA Committee meeting. On 4/18/17 at 8:20PM, an interview was The QA committee will assess and modify conducted with Nurse #1. She stated the the action plan as needed to ensure procedure for cleaning the glucometer was to use continual compliance Completed 5/17/17 a germicidal wipe and wipe the glucometer off for approximately 10 seconds and let dry for 1 minute. She stated she cleaned the glucometer before beginning and after each use on resident. She reviewed the instructions on the germicidal wipe and stated she did not know it should remain wet for 3 minutes. On 4/18/17 at 8:35PM, an interview was conducted with the Director of Nursing who stated

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEA						FORM	: 05/19/2017 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (, AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	-	(X3) DATE COMPI	SURVEY
		345015	B. WING			04/*	19/2017
NAME OF PROVIDER OR SUPF	PLIER			STREET ADDRESS, CITY, S			
CLAPPS CONVALESCEN	TNH			500 MOUNTAIN TOP DRIV ASHEBORO, NC 27203			
PREFIX (EACH D	EFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
guidelines for stated she ex manufacturer cleaning and 2. On 4/18/17 observed obt Nurse #1 rem basket, wiped wipe for appre- blood sugar, - germicidal wi glucometer in A review of M germicidal wi wipe to remo- and thorough must remain additional wip three minutes On 4/18/17 ai conducted wi procedure for a germicidal vi minute. She before beginn She reviewed wipe and stat remain wet fo On 4/18/17 ai	owed the cleanin pected s 's instruct disinfect 7 at 8:10 aning R loved the lanufactor ope for 13 the base anufactor ope state /e heavy ly wet su visibly w les if new signer cleanin wise if new stated s cleanin visibly w ly wet su visibly w la su cleanin vipe and l the inst ed she co r 3 minu the bio owed the la suble co la suble co stated s suble co suble co stated s suble co suble co s	 a CDC and SPICE g the glucometer. She staff to follow the ctions and facility policy for ting the glucometers. DPM, Nurse #1 was esident #219's blood sugar. e glucometer from the cometer with a germicidal by 10 seconds, obtained the the glucometer with a 3 seconds and put the sket. urer's instructions for the ed, in part, to disinfect, use a y soil. Unfold a clean wipe urface. Treated surface to assure continuous ntact time. <i>A</i>, an interview was e #1. She stated the glucometer off for onds and let dry for 1 he cleaned the glucometer off for onds and let dry for 1 he cleaned the germicidal did not know it should 	F 44				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/19/2017 MAPPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>			(X3) DATE SURVEY COMPLETED		
		345015	B. WING			04/	19/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
CLAPPS (CONVALESCENT NH				500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203			
(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 SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	cleaning and disinfect 3. On 4/18/17 at 8:17 obtaining Resident #1 wiped the glucometer 10 seconds, obtained the glucometer with a seconds and placed t A review of Manufactu germicidal wipes state wipe to remove heavy and thoroughly wet su must remain visibly w additional wipes if new three minutes wet cor On 4/18/17 at 8:20PM conducted with Nurse procedure for cleaning a germicidal wipe and approximately 10 sec minute. She stated si before beginning and She reviewed the inst wipe and stated she of remain wet for 3 minu On 4/18/17 at 8:35PM conducted with the Di the facility followed th	staff to follow the ctions and facility policy for ting the glucometers. PM, Nurse #1 was observed 172's blood sugar. Nurse #1 with a germicidal wipe for the blood sugar, cleaned germicidal wipe for 10 he glucometer in the basket. urer's instructions for the ed, in part, to disinfect, use a y soil. Unfold a clean wipe urface. Treated surface to for a full 3 minutes. Use eded to assure continuous ntact time. A, an interview was e #1. She stated the g the glucometer was to use d wipe the glucometer off for onds and let dry for 1 he cleaned the glucometer after each use on resident. tructions on the germicidal did not know it should ites. A, an interview was irector of Nursing who stated e CDC and SPICE g the glucometer. She	F	441				
	cleaning and disinfect	ctions and facility policy for ting the glucometers.						

Facility ID: 923103

If continuation sheet Page 36 of 57
	-	ID HUMAN SERVICES				FOR	D: 05/19/2017 M APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE	<u>O. 0938-0391</u> E SURVEY PLETED	
		345015	B. WING			04	/19/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPPS (CONVALESCENT NH				00 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 441	 5. On 4/18/17 at 4:52 observed obtaining R Nurse #2 obtained Rereturned to the medic glucometer with an al glucometer to the dra stated she usually cle alcohol wipe. A review of Manufactu germicidal wipes state wipe to remove heavy and thoroughly wet su must remain visibly w additional wipes if new three minutes wet corr On 4/18/17 at 8:35PM conducted with the Di the facility followed th guidelines for cleaning stated she expected so manufacturer's instruc- cleaning and disinfect 4. Resident #160 was admission MDS dated cognitively intact with 	2PM, Nurse #2 was esident #118's blood sugar, ation cart, wiped the cohol wipe and returned the wer in the cart. Nurse #2 aned the glucometer with an urer's instructions for the ed, in part, to disinfect, use a y soil. Unfold a clean wipe urface. Treated surface ret for a full 3 minutes. Use eded to assure continuous ntact time. A, an interview was irector of Nursing who stated e CDC and SPICE g the glucometer. She staff to follow the ctions and facility policy for ting the glucometers.	F 4	.41			
	April physician orders levels were to be test (device for monitoring times daily.	4/18/17 at 7:14 PM, Nurse forming a blood glucose					

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		D HUMAN SERVICES				FORM): 05/19/2017 // APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	ECONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345015	B. WING		_	04/	19/2017
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CLAPPS C	ONVALESCENT NH			00 MOUNTAIN TOP DRIVI ASHEBORO, NC 27203			
(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 441 F 514 SS=D	Prior to testing she tor rolling cart and proceed down using a Santi-w for 30 seconds then p #160's blood glucose completed his blood g to her cart and again proceeded to wipe the seconds. She dispose the glucometer to the her practice to use the glucometer using the minute" before using it returning it to the cart not trained specifically instructions for disinfer was just advised to w with the Santi-wipes in On 4/18/17 at 8:35PM conducted with the Di the facility followed th guidelines for cleaning stated she expected s manufacturer's instruct cleaning and disinfect 483.70(i)(1)(5) RES RECORDS-COMPLE LE (i) Medical records. (1) In accordance with standards and practice	60 using a glucometer. ok the glucometer from her eded to wipe the device ipe. She wiped the device roceeded to check Resident e level. After Nurse #4 glucose check, she returned took a fresh Santi wipe and e glucometer for 45 ed of the wipe and returned cart. Nurse #4 stated it was e Santi-wipe to disinfect the Santi wipe for "about a it on a resident and before . Nurse #4 stated she was y on the manufacture ecting the glucometers. She ipe the glucometers down in between residents. 1, an interview was rector of Nursing who stated e CDC and SPICE g the glucometer. She staff to follow the ctions and facility policy for ting the glucometers. TE/ACCURATE/ACCESSIB	F 441				5/17/17
	(i) Complete;						

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STATEMENT OF DEFICIENCIES AND FLAND CONTRUCTION AND FLAND CONTRUCTION A BUILDING 020 MULTIPE CONTRUCTION A BUILDING 021 MULTIPE CONTRUCTION A BUILDING A BUILDING (MULTIPE CONTRUCTION A BUILDING (MULTIPE CONTRUCTION (MULTIPE CONT			D HUMAN SERVICES			FORM	: 05/19/2017 APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 2P CODE CLAPPS CONVALESCENT NH STREET ADDRESS. CITY, STATE, 2P CODE (M) ID PREEDED SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUSC DEPTICUE) (EACH OFFICIENCY MUSC DEPTICUE) (II) Accurately documented; 0 (II) Accurately documented; 0 (III) Readily accessible; and F 514 (I) Accurately documented; (III) Accurately documented; (III) A record of the resident; F 514 (III) A record of the resident's assessments; (III) The comprehensive plan of care and services provided; F 514 (V) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; F 514 Resident Records (V) Physician's, nurse's, and other licensed professional's progress notes; and F 514 Resident Records (V) Laboratory, radiology and other diagnostic stroker sprofs as required under §483.50. F 514 Resident Records The findings included: The findings included: F 514 Resident Records Resident #188 was admitted to the facility on The findings included: F 614 Resident Records	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		(X3) DATE SURVEY COMPLETED	
S00 MOUNTAIN TOP DRIVE ASHEBORO, NC 2723 OWINESSEED IN THE PROCEED IN TULL RECULTORY OR LSC DENTIFYING INFORMATION) PROVER PLANOF CORRECTION PROVENT AND OF CORRECTION (i) A record of the resident's assessments; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (v) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other licensed provides as required under \$483.50. This REQUIREMENT is not met as evidenced by: The findings included: The findings included: Resident #188 was admitted to the facility on F514 Resident Records Complete/Accurate F514 Resident Records Complete/Accurate 1. Corrective actions taken for those resident \$188 was admitted to the facility on 1. Corrective actions taken for those resident \$188 was admitted to the facility on			345015	B. WING		04/1	9/2017
CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 (Ma) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST ERECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PREFIX (EACH CORRECTIVA COTION USE IDENTIFYING INFORMATION) D PREFIX TAG F 514 Continued From page 38 F 514 (ii) Accurately documented; (iii) Readily accessible; and F 514 (iv) Systematically organized (5) The medical record must contain (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (v) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; F514 Resident Records (v) Physician's, nurse's, and other licensed professional's progress notes; and F514 Resident Records (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by; Based on record review and staff interview the facility failed to maintain an accurate allergy list for 1 of 5 residents reviewed for unnecessary drug review (Resident #188). F514 Resident Records Complete/Accurate 1. Corrective actions taken for those residents found to have been affected by the deficient practice. 1. Corrective.	NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CMUD PREEX TAG SUMMARY STATEMENT OF DEFICIENCIES REQUIATORY OR LSCIDENTIFYING INFORMATION) p. PRETX TAG PROVIDERS FLAN OF CORRECTION (PACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY) cc F 514 Continued From page 38 F 514 cross-Reference To The APROPRIATE DEFICIENCY) cc (ii) Accurately documented; (iii) Readily accessible; and r r r (ii) Accurately documented; (iii) Readily accessible; and r r r (i) Sufficient information to identify the resident; r r r r (iii) A record of the resident's assessments; r r r r r (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; r r r (v) I baboratory, radiology and other diagnostic services reports as required under §483.50. This RECURENT is not met as evidenced by; F514 Resident Records Complete/Accurate r The findings included: Resident #188 was admitted to the facility on r r. Corrective actions taken for those residents found to have been affected by the deficient practice.				50	00 MOUNTAIN TOP DRIVE		
Prečink TAG (EACH DEFICIENCY NUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉTIX TAG CICACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCES TO THE APPROPRIATE DEFICIENCY) CC F 514 Continued From page 38 F 514 F 514 F 514 Image: Continued From page 38 F 514 Image: Continued From page 38 F 514 Image: Continued From page 38 Image: Continued From Page: Contineer Contine From Page: Continued From Page: Contineer Continued F	OLANOC			A	SHEBORO, NC 27203		
(ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under \$483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate allery list for 1 of 5 resident services dry unnecessary drug review (Resident #188). The findings included: Resident #188 was admitted to the facility on	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
 (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate allergy list for 1 of 5 residents reviewed for unnecessary drug review (Resident #188). The findings included: Resident #188 was admitted to the facility on 	F 514	Continued From page	38	F 514			
(iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate allergy list for 1 of 5 residents reviewed for unnecessary drug review (Resident #188). The findings included: Resident #188 was admitted to the facility on		(ii) Accurately docume	ented;				
 (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under \$483.50. This REQUIREMENT is not met as evidenced by; Based on record review and staff interview the facility failed to maintain an accurate allergy list for 1 of 5 residents reviewed for unnecessary drug review (Resident #188). The findings included: Resident #188 was admitted to the facility on 		(iii) Readily accessible	e; and				
 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate allergy list for 1 of 5 residents reviewed for unnecessary drug review (Resident #188). The findings included: Resident #188 was admitted to the facility on 		(iv) Systematically org	ganized				
 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate allergy list for 1 of 5 residents reviewed for unnecessary drug review (Resident #188). The findings included: Resident #188 was admitted to the facility on 		(5) The medical recor	d must contain-				
 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate allergy list for 1 of 5 residents reviewed for unnecessary drug review (Resident #188). The findings included: Resident #188 was admitted to the facility on 		(i) Sufficient information	on to identify the resident;				
provided;(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;(v) Physician's, nurse's, and other licensed professional's progress notes; and(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate allergy list for 1 of 5 residents reviewed for unnecessary drug review (Resident #188).The findings included: Resident #188 was admitted to the facility on		(ii) A record of the res	ident's assessments;				
and resident review evaluations and determinations conducted by the State;(v) Physician's, nurse's, and other licensed professional's progress notes; and(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate allergy list for 1 of 5 residents reviewed for unnecessary drug review (Resident #188).The findings included: Resident #188 was admitted to the facility on			ve plan of care and services				
professional's progress notes; and(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate allergy list for 1 of 5 residents reviewed for unnecessary drug review (Resident #188).F514 Resident Records Complete/Accurate1. Corrective actions taken for those residents found to have been affected by the deficient practice.1. Corrective actions taken for those resident practice.		and resident review e	valuations and				
services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate allergy list for 1 of 5 residents reviewed for unnecessary drug review (Resident #188). The findings included: Resident #188 was admitted to the facility on							
facility failed to maintain an accurate allergy list Complete/Accurate for 1 of 5 residents reviewed for unnecessary 1. Corrective actions taken for those drug review (Resident #188). 1. Corrective actions taken for those The findings included: the Resident #188 was admitted to the facility on deficient practice.		services reports as re This REQUIREMENT	quired under §483.50.				
drug review (Resident #188). 1. Corrective actions taken for those residents found to have been affected by the deficient practice. Resident #188 was admitted to the facility on 4. Corrective actions taken for those residents found to have been affected by the deficient practice.		facility failed to mainta	ain an accurate allergy list				
The findings included: the Resident #188 was admitted to the facility on deficient practice.			-			by	
Resident #188 was admitted to the facility on		The findings included	:		the	by	
10/10/10/10/10/10/10/10/10/10/10/10/10/1		10/15/16 with diagnos pain, anemia, Alzhein most recent Minimum	ees that included right hip ner's and dementia. The Data Set (MDS)		" On 4/20/17 RN received order to remove Tylenol from resident #188 alle list. Resident showed no side effects o		

Event ID: GX5O11

Facility ID: 923103

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 514 Continued From page 39 F 514 #188 received scheduled pain medication. The MDS further revealed Resident #188 was 2. Residents having the potential to be cognitively impaired as evidenced by a brief affected by the same deficient practice interview for mental status (BIMS) score of 1. were identified and the following action Review of Resident #188's red allerov tab in her taken: physical medical record had no allergies On 5/3/17 Pharmacy completed identified. view of Resident #188's History and physical reviewed of all residents listed allergies for Assessment (H&P) dated 10/17/16 indicated accuracy. Two records were found to be Resident #188 was admitted to the facility for incorrect. Findings were given to the physical therapy and occupational therapy Assistant Director of Nursing for following a hospital stay for a fall that resulted in a correction. right hip fracture. The H&P identified the flowing On 5/3/17 the ADON notified MD of drug allergies: Darvocet, penicillin, Sulfa, and findings and corrections made at that Allegra. time. 3. Measures or systemic changes put in Review of Physician order dated 10/17/16 stated, place to ensure the corrective actions do Tylenol 650 milligrams (mg) by mouth (po) 4x a not reoccur: day (QID). The pharmacy will perform monthly Review of Resident #188's Medication reviews of each residents □ allergy list. Administration Record (MAR) for April 2017, Any discrepancies will be reported to the March 2017, Feb 2017, January 2017, December ADON to obtain clarification. 2016, November 2016, October 2016 included The Director of Nursing and/or ADON acetaminophen as an allergy. will re-educated all Licensed Nurses on the process of reviewing the residents□ Review of Medication Aide #1 note dated allergy list each time a new medication 10/18/16 stated Tylenol 325mg tablet secluded order is received. All Licensed Nurses will for 10/18/16 8:00am was not administered due to receive education prior to their next patient allergies list. The note continued with the scheduled shift to work. nurse was made aware. Completed: 5/17/17 Review of Medication Aide #1 note dated 4. How the corrective actions will be 10/18/16 stated Tylenol 325mg tablet secluded monitored to ensure the deficient practice for 10/18/16 at 12:00pm was not administered will due to patient allergies list. The note continued not reoccur, i.e. quality assurance with the nurse was made aware. measures implemented:

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN TOP DRIVE CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 514 Continued From page 40 F 514 Interview with Medication Aide #1 on 4/18/17 at The DON and or ADON will monitor 5:31 pm revealed he was made aware of 10 resident records for accurate allergy resident's allergies through the resident's lists. This will be done every week for 4 electronic medical record. He stated that as a weeks, then taper to monthly for 2 months. QA Audit tools were developed Medication Aid he was not responsible for contacting the physician in regards to notification to record the results of the monitoring. of an allergy. He indicated that he only Pharmacy will perform a monthly communicated the allergy to the nurse on duty. review of the previous month s The nurse on duty would be responsible for recommendations for completion of contacting the physician and notify them of any recommendations made and notify the discrepancy in any medication. DON and ADON of any incomplete orders The DON will take the audits to the Interview with Nurse #7 on 4/19/17 at 8:00am QA Committee and results of that revealed she administered medications to monitoring will be reviewed and discussed Resident #188. She stated that she identified in the monthly QA Committee meeting. what medications residents were allergic to The QA committee will assess and modify through documentation in the resident's electronic the action plan as needed to ensure medical record, physical medical record and continual compliance physician orders. She stated that she recalled Completed: 5/17/17 Resident #188's allergy to acetaminophen but should have been removed from Resident #188's allergy list. She stated she recalled the family of Resident #188 indicating the resident was not allergic to the medication and was unsure as to why it was listed as an allergy. Nurse #7 indicated that she had given Resident #188 her scheduled Tylenol that am and had not notified the physician of the allergy still being listed on the electronic record. Interview with the Assistant Director of Nursing (ADON) on 4/18/17 at 3:27pm revealed that upon admission the facility would use the list of allergies identified on the discharge summary from the hospital. The ADON indicated that she would further discuss allergies with the resident's family or the resident. The ADON stated if the resident's family said the resident could have the medication and there is no allergy, the physician

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/19/2017 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	E SURVEY PLETED
		345015	B. WING			04	/19/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPPS	CONVALESCENT NH				500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 514	order to assess the real a resident had an aller would be an order to a allergy. She indicated 10/18/16 written by M have been followed u communicated the correvealed that her exception up with the phy clarifying the medicate ADON stated she countrising note in regard resident #188's Tylen. Interview with the Direct 4/19/17 at 9:47am revidentified by the disch facility also became a instances the resident as a rash, interview upon admission. She be notified. The note on 10/18/16 indicated Tylenol to Resident # was listed as an allerge expectation that there weresident had received physician would see i allergy. The DON state at the physician was notified. The note on the resident had received physician would see i allergy. The DON state at the physician would see is noted in the resident of the resident	would write a telephone esident for the allergy. When rgy to a medication there monitor the resident for that that the note written on ledication Aid #1 should p by the nurse he ncern to. She further eption was that the nurse sician with a nursing note ion use and allergy. The uld not find documentation or ds to Med Aide holding ol. ector of Nursing (DON) on vealed allergies were targe hospital records. The ware of allergies in t was having a reaction such with the resident or family e stated the physician would written by Medication Aid #1 the Med Aid did not give 188 because the medication gy. She revealed it was her urse that was notified by the physician and notify the vas an allergy noted and the the medication. The f the allergy was truly an ted that there should have written that identified the d in regards to the allergy. that current allergies be	F	514			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		` '	IPLETED
		345015	B. WING		04	4/19/2017
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODI	Ξ	
CLAPPS (CONVALESCENT NH			0 MOUNTAIN TOP DRIVE SHEBORO, NC 27203		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 514	previous admission of Resident #188 could She further stated that Resident #188 the all over and were not rel have clarified the ord acetaminophen out of discrepancy from occ her expectation that the standards of care and with the physician. Interview with the Ph am revealed he was Resident #188 had hat facility. He further re- had an allergic reaction medication that had a Resident #188 had that admission and had m indicated that he didr allergy listed in Resident until today (4/19/17) If that his expectation v Resident #188 had a medical record to ace have been removed to list. 483.75(g)(1)(i)-(iii)(2) COMMITTEE-MEMB	facility had a fax from a ated 3/4/16 that stated have the Tylenol per family. at when they readmitted ergies would have pulled moved. The nurse should er and taken the allergy to f the system to prevent the surring. She revealed it was he facility staff follow the d clarify resident allergies ysician on 4/19/17 at 10:57 familiar with resident #188. ad previous admission at the evealed that Resident #188 on to a combination acetaminophen in it. kken acetaminophen since o allergic reaction to it. He I't become aware of the lent #188's medical record by the facility. He indicated vas to be notified that n allergy identified in the etaminophen so that it could from the resident's allergy (i)(ii)(h)(i) QAA ERS/MEET	F 514			5/17/17
	QUARTERLY/PLANS (g) Quality assessme (1) A facility must ma and assurance comm minimum of:	nt and assurance. intain a quality assessment				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/19/2017 / APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345015	B. WING			04/	19/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPPS C	CONVALESCENT NH				00 MOUNTAIN TOP DRIVE SHEBORO, NC 27203		
(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 SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 520	Continued From page (i) The director of nurs (ii) The Medical Direct (iii) At least three other staff, at least one of we administrator, owner, individual in a leaders (g)(2) The quality asse committee must : (i) Meet at least quart coordinate and evaluat identifying issues with assessment and assu necessary; and (ii) Develop and implet action to correct ident (h) Disclosure of infor Secretary may not recorrected of such commisuch disclosure is relation	e 43 sing services; tor or his/her designee; er members of the facility's vho must be the a board member or other ship role; and essment and assurance erly and as needed to ate activities such as n respect to which quality urance activities are ement appropriate plans of iffied quality deficiencies; mation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this aith attempts by the and correct quality		520			
	by: Based on observation record review, the fac and Assurance (QAA) maintain implemented	is not met as evidenced n, staff interviews, and sility ' s Quality Assessment) Committee failed to d procedures and monitor at the committee put into			F520 QA Committee-Members/Meet Quarterly/Plans 1. Corrective actions taken for those residents found to have been affected	by	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 520 Continued From page 44 F 520 place following the 4/14/16 recertification survey. the deficient practice. This was for a recited deficiency in the area of Accidents (F323). This deficiency was cited 4/25/17 Physical Therapy again on the current recertification survey of re-evaluated Resident # 70 to confirm the use of Stand Lift as safe means of 4/19/17. The continued failure of the facility during two federal surveys of record show a transfer. The Stand Lift was determined to pattern of the facility 's inability to sustain an be an appropriate mechanical lift to be effective Quality Assessment and Assurance used for the residents I transfers to and program. The findings included: from surfaces. This tag is cross referenced to: 2. Residents having the potential to be affected by the same deficient practice F323 - Accidents: Based on observation, staff were interviews and record review, the facility failed to identified and the following action evaluate and monitor the safe continued use of a taken: mechanical standing lift for a resident who All falls for the last month were sustained a fall during the use of the standing lift reviewed to determine if a therapy for a transfer for 1 (Resident #70) of 1 residents referral/evaluation was necessary. No falls reviewed for accidents. using mechanical lifts were noted. Completed:5/5/17 During the recertification survey of 4/14/16 the facility was cited F323 for failing to ensure hazard Review of all residents requiring the chemicals were stored out of reach of residents use of a mechanical lift will be completed as evidenced by leaving disinfectant/deodorant by physical therapy to determine safe cans on top of hand rails. On the current transfers to and from surfaces. recertification survey of 4/19/17 the facility was Completed:5/17/17 cited for failure to evaluate and monitor the safe continued use of a mechanical standing lift for a 3. Measures or systemic changes put in resident who sustained a fall during the use of the place to ensure the corrective actions do standing lift. not reoccur: An interview was conducted with the Director of The Director of Nursing and/or Nursing (DON) on 4/19/17 at 1:11 PM. She Assistant Director of Nursing will continue stated she was the head of the facility 's QAA to review incident/accident forms and Committee. She indicated the committee document any new interventions/referrals consisted of the Administrator, Assistant Director etc. These entries will be dated and timed of Nursing (ADON), Minimum Data Set (MDS) at the time of the initial incident report Coordinator #1, MDS Coordinator #2, Admissions review. The Fall Team Members will Director, Dietary Manager, Social Worker, review the reports again weekly during the

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 520 Continued From page 45 F 520 Therapy Manager, Medical Director, Floor Nurse, interdisciplinary fall team meeting. and Nursing Assistant. She stated the committee The DON and/or the ADON will be notified immediately of a fall the occurring met quarterly. during the use of a mechanical lift. The DON indicated she was aware Accidents was Physical Therapy will be notified a repeat citation from the 4/14/16 recertification immediately of a fall occurring during the survey. She indicated the previous Plan of use of a mechanical lift. Therapy will Correction (POC) included several months of assess the resident within 24 hours of the audits that were monitored by the Housekeeping fall to ensure the appropriate mechanical Manager. She stated she believed the current lift is being used. All falls will be discussed during daily citation was unrelated to their previous POC. She additionally stated she believed this was a repeat Department Meetings. Those in deficiency because the area of accidents was so attendance will be; Administrator, Director broad that a variety of items fell under this of Nursing, Assistant Director of Nursing, categorization. Director of Social Services, Admission Director, Transition Care Nurse, MDS Coordinators, Dietary Manager, Director of Physical/Occupational Therapy, Medical Record Manager, Human Resources Manager, Business Office Manager, Staff Coordinator, Environmental Services Manager, Maintenance Manager. Fall meetings are currently scheduled to occur weekly. The MDS Coordinator has been appointed to conduct/lead the interdisciplinary meeting in the absence of the DON/ADON to assure the falls are reviewed by the interdisciplinary at least weekly. All Licensed nurses and Nursing Assistants will be in-serviced on the therapy referral process listed above by the DON and/or ADON. Observations using the Environmental Hazard Check List will be conducted weekly by various departments to assess for potential areas that could pose an accident hazard to the residents with any

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/19/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345015	B. WING		04/19/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	CONVALESCENT NH			500 MOUNTAIN TOP DRIVE	
ULAITU				ASHEBORO, NC 27203	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 520	Continued From page	e 46	F 520	 immediate threats reported to the Dr and/or ADONcorrected upon discover Completion Date: 5/17/17 How the corrective actions will be monitored to ensure the deficient prawill not reoccur, i.e. quality assurance meass implemented: The Administrator will audit all F Investigation Reports to assure the review conducted by the DON and/or ADON has been completed and documented. The auditing will occur follows: All reports weekly for 1 mon then at least 5 per month for 3 mont The DON/ADON will monitor all involving a mechanical lift to assure therapy referral was initiated and an evaluation/screen completed. All fa weekly for 1 month, then at least 5 p month for 3 months. QA Audit tools were developed record the results of the monitoring. DON will take the audits to the QA Committee and results of that monit will be reviewed and discussed in the monthly QA Committee will assess a modify the action plan as needed to ensure continual compliance the result and modify the action plan as needed to ensure continual compliance the results and modify the action plan as needed to ensure continual compliance the result and modify the action plan as needed to ensure continual compliance the result and modify the action plan as needed to ensure continual compliance the result and modify the action plan as needed to ensure continual compliance. 	ery. e actice sures Fall initial or r as nth, ths. I falls a alls oer to The oring ie and sults of ittee sess

Event ID: GX5O11

Facility ID: 923103

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/19/2017 1 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY
		345015	B. WING			04/'	19/2017
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
CLAPPS C	CONVALESCENT NH			00 MOUNTAIN TOP DRIVE SHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	: 47	F 520	Completed:5/17	7/17		
F 526 SS=D	483.70(o)(1)-(4) Hosp	lice	F 526		,		5/17/17
	(o) Hospice services.						
	(1) A long-term care (the following:	LTC) facility may do either of					
	(i) Arrange for the pro through an agreemen Medicare-certified hos						
	(ii) Not arrange for the services at the facility	e provision of hospice through an agreement with					
	in transferring to a fac	spice and assist the resident cility that will arrange for ce services when a resident					
	through an agreemen (o)(1)(i) of this section	furnished in an LTC facility t as specified in paragraph n with a hospice, the LTC following requirements:					
	to	spice services meet s and principles that apply services in the facility, and to					
	the timeliness of the s						
	that is signed by an at the	eement with the hospice uthorized representative of rized representative of the					
	LTC facility before hos	spice care is furnished to ten agreement must set out					

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/19/2017 MAPPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345015	B. WING			04/	19/2017	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CLAPPS (CONVALESCENT NH				00 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 526	Continued From page	÷ 48	F	526				
	(A) The services the h	nospice will provide.						
	(B) The hospice's res the appropriate hospic specified in §418.112	•						
		LTC facility will continue to the resident's plan of care.						
	communication will be							
	(E) A provision that th notifies the hospice al	e LTC facility immediately bout the following:						
	(1) A significant chang mental, social, or emo	ge in the resident's physical, otional status.						
	(2) Clinical complication alter the plan of care.	ons that suggest a need to						
	(3) A need to transfer for any condition.	the resident from the facility						
	(4) The resident's dea	ath.						
	responsibility for deter course of hospice car	g that the hospice assumes rmining the appropriate re, including the age the level of services						
		at it is the LTC facility's sh 24-hour room and board						

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	-	D HUMAN SERVICES				FORM): 05/19/2017 1 APPROVED 0. 0938-0391
STATEMENT	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345015	B. WING		_	04/	19/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CLAPPS	CONVALESCENT NH			00 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203			
(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 BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 526	care, meet the resider nursing needs in coor representative, and er provided is appropriat resident's needs. (H) A delineation of the including but not limited direction and manage counseling (including bereavement); social supplies, durable meet necessary for the pall associated with the ter conditions; and all oth necessary for the care illness and related cor (I) A provision that wh personnel are respons of prescribed therapied determined appropriat delineated in the hosp facility personnel may where permitted by St the LTC facility. (J) A provision stating report all alleged violation mistreatment, neglect and physical abuse, in source, and misappro by hospice personnel administrator immediation becomes aware of the	nt's personal care and dination with the hospice neure that the level of care levely based on the individual the hospice's responsibilities, ed to, providing medical ment of the patient; nursing; spiritual, dietary, and work; providing medical dical equipment, and drugs iation of pain and symptoms rminal illness and related the rospice services that are e of the resident's terminal nditions. Then the LTC facility sible for the administration tes, including those therapies te by the hospice and bice plan of care, the LTC r administer the therapies tate law and as specified by that the LTC facility must attons involving , or verbal, mental, sexual, ncluding injuries of unknown priation of patient property , to the hospice ately when the LTC facility e alleged violation.	F 526				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/19/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345015	B. WING			04/	/19/2017
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPPS (CONVALESCENT NH				500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 526	Continued From page bereavement services (3) Each LTC facility a hospice care under a designate a member interdisciplinary team working with hospice coordinate care to the LTC facility staff and f interdisciplinary team clinical background, for scope of practice act, assess the resident o that has the skills and resident. The designated interd responsible for the fol (i) Collaborating with and coordinating LTC the hospice care plan residents receiving the (ii) Communicating wi and other healthcare provision of care for th conditions, and other of care for the patient (iii) Ensuring that the with the hospice media attending physician, a participating in the pro- as needed to coordina medical care provideo	e 50 s to LTC facility staff. arranging for the provision of written agreement must of the facility's who is responsible for representatives to resident provided by the nospice staff. The member must have a unction within their State and have the ability to r have access to someone d capabilities to assess the lisciplinary team member is lowing: hospice representatives facility staff participation in ning process for those ese services. th hospice representatives providers participating in the ne terminal illness, related conditions, to ensure quality and family. LTC facility communicates ical director, the patient's ind other practitioners povision of care to the patient ate the hospice care with the		526	DEFICIENCY)		
	(iv) Obtaining the follo	owing information from the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345015	B. WING _			04/	19/2017
NAME OF P	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CLAPPS (CONVALESCENT NH				0 MOUNTAIN TOP DRIVE SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 526	 to each patient. (B) Hospice election (C) Physician certific the terminal illness sp (D) Names and conta personnel involved in patient. (E) Instructions on he 24-hour on-call system 	hospice plan of care specific form. ation and recertification of pecific to each patient. act information for hospice hospice care of each	F 5	526			
	 any) orders specific to (v) Ensuring that the lorientation in the policifacility, including patients and record keeping refurnishing care to LTC (4) Each LTC facility president's written plant most recent hospice president's written plant most recent hospice president's the service of the service	LTC facility staff provides cies and procedures of the ent rights, appropriate forms, equirements, to hospice staff C residents. providing hospice care under must ensure that each of care includes both the blan of care and a vices furnished by the LTC intain the resident's highest mental, and psychosocial					

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PRINTED: 05/19/2017 FORM APPROVED

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345015 B. WING 04/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 526 Continued From page 52 F 526 Based on family interview, staff interview, and F526 Hospice Services record review, the facility failed to coordinate care with the hospice provider for 1 of 1 residents 1. Corrective action taken for those (Resident #281) reviewed for hospice. The residents found to have been affected by findings included: deficient practice. On 4/18/17 DON received physician Resident #281 was admitted to the facility on order for resident #281 continuation of 4/7/17 with multiple diagnoses that included hospice services, documentation of Alzheimer's. hospice plan of care, hospice election form and hospice certification of terminal illness for resident. The documentation A family interview for Resident #281 was conducted on 4/17/17 at 12:47 PM. The family was placed on chart and a label indicating member indicated Resident #281 had been on the resident was receiving hospice hospice services for several months and services. continued on hospice when she was transferred to this facility on 4/7/17. They reported Resident 2. Residents having the potential to be #281 was bed bound and non-verbal. affected by the same deficient practice were identified and the following action A review of the medical record revealed an FL2 taken. Form (a form completed prior to admission to a On 5/5/17 the DON reviewed all nursing home that contained diagnoses, charts of patients receiving hospice medications, and care needed) completed on services to ensure that all required info 4/5/17 for Resident #281 that indicated she was in medical record. All records were began hospice services on 10/1/16 with a primary found to have appropriate Hospice chart diagnosis of Alzheimer's. This form was received labeling and documents. by the facility on 4/5/17 prior to Resident #281's On 5/5/17 Administrator contacted admission. A Hospice Standing Orders and hospice to validate accurate list of hospice Comfort Pak (medications used when needed to patients being followed in facility. relieve symptoms that commonly arise in terminally ill patients) form was signed by 3. Measures or systemic changes put in Resident 281's physician and received at the place to ensure the corrective actions do facility on 4/15/17. not reoccur. On 5/5/17 Administrator in serviced A further review of Resident #281's medical admission director and admission nurses record (hard copy and electronic copy) revealed on the procedure to follow when admitting none of the following documents: physician's a hospice patient. order for hospice, hospice plan of care, hospice Admission Director will put a note in election form, or hospice certification of terminal our electronic medical record informing all illness. staff that a patient will be receiving

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					OMB NO. 0938-039 (X3) DATE SURVEY		
INTERNENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345015		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		B. WING		04/19/2017			
NAME OF PROVIDER OR SUPPLIER CLAPPS CONVALESCENT NH				STREET ADDRESS, CITY, STATE, ZIP COD			
					0 MOUNTAIN TOP DRIVE SHEBORO, NC 27203		
				~	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG				(X5) COMPLETIC DATE
F 526	Continued From page	e 53	F 52	26			
			_		hospice services.		
	An interview was con	ducted with Nurse #1 on			" Admissions Director will commun	icate	
		She stated she was familiar			to admitting nurse when a patient will		
	with Resident #281.			admitted under hospice services.			
	Resident #281 was a			" Admitting nurse will contact physi	cian		
	the resident was on h			and obtain an order for hospice servic	es.		
	revealed it was not ur			" Admitting nurse will contact hospi	ce to		
	admission to the facil			inform that patient has been admitted	to		
	hospice nurse who in			the facility.			
	was on hospice servi			 Hospice will place on pertinent 			
	hospice nurse provide			information on the chart.			
	Orders and Comfort F						
	Resident #281 's phy			4. How the corrective actions will be			
	form was signed by the			monitored to ensure the deficient prac	tice		
	to the facility on 4/15/			will not reoccur, i.e. quality assurance			
	to the facility). Reside was reviewed with Nu			measures implemented. The Administrator will monitor aud	lito		
	was no physician 's o			on weekly basis for 4 weeks; every 2	JIIS		
	plan of care, hospice			weeks for 30 days and the monthly for	- 2		
	certification of termina			months to assure accuracy.	5		
	in the medical record				" The results of that monitoring will	ho	
					reviewed and discussed in the monthl		
	An interview was con	ducted with the Admissions			QA Committee meeting. The QA	,	
		3:50 PM. She stated she			committee will assess and modify the		
		sion for Resident #281. She			action plan as needed to ensure conti	nual	
		known Resident #281 was			compliance.		
	-	The Admissions Nurse			Completed: 5/17/17		
		nt was transferred from					
	another facility while						
		ormed by the FL2 and/or					
	•	ility verbally. She revealed					
	the previous facility h						
		as on hospice services and					
	she was unable to rec						
		ice services. She stated					
		Resident #281 was on					
	-	would have obtained a					
	physician's order for l	nospice when she verified					

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	-	D HUMAN SERVICES					FORMA	05/19/2017 APPROVED
CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		345015	B. WING				04/19	9/2017
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE			
	ONVALESCENT NH			500 MOUNTAIN T	OP DRIVE			
CLAPPS C	ONVALESCENT NH			ASHEBORO, NO	C 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACI	ROVIDER'S PLAN OF CORRE H CORRECTIVE ACTION SH B-REFERENCED TO THE API DEFICIENCY)	IOULD BE		(X5) COMPLETION DATE
F 526	nurse that the resident completed the admiss FL2 form that indicate hospice services was Nurse. She revealed information regarding Resident #281. An interview was come Director on 4/18/17 at coordinated the admiss She reported that she was on hospice service this was indicated on the FL2 form was give The Admissions Direct information indicated form must have just b Admissions Nurse. An interview was come Nursing (DON) on 4/1 asked how staff were on hospice she stated informed was by a lab outside binding of the residents on hospice. Resident #281 was re There was no label or chart that indicated sh DON revealed she ex chart. The admissions D Admissions Nurse rev admission paperwork	Id have reported to the floor it was on hospice when she sion. The information on the ed Resident #281 was on shared with the Admissions she had overlooked the hospice services for ducted with the Admissions a 3:55 PM. She stated she asion for Resident #281. believed Resident #281 ces and she recalled that her FL2 form. She stated en to the Admissions Nurse. ctor revealed the hospice on Resident #281's FL2 een missed by the ducted with the Director of 8/17 at 4:10 PM. When informed if a resident was d the primary way staff were bel that was placed on the hard copy chart for all The hard copy chart of eviewed with the DON. In Resident #281's hard copy he was on hospice. The pected a label to be on the s process was then N. She verified the by the Admissions Nurse birector. She stated that the viewed the FL2 and other	F 52					

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	-	ID HUMAN SERVICES				FORM): 05/19/2017 1 APPROVED		
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED			
		345015	B. WING		_	04/	19/2017		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-			
			5	500 MOUNTAIN TOP DRIVE					
CLAPPS (CONVALESCENT NH		4	SHEBORO, NC 27203	}				
(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 526	that indicated Resider services. She stated should have then repor- the resident was on h was completed. Resi (electronic and hard of DON. She verified the for hospice for Reside she expected a physic be on the medical recover verified there was no hospice election form terminal illness in Res record. She stated no brought in all of that p within a couple of day indicated she expected in the medical record. lack of hospice docum and was due to an ov Nurse. The DON rep contact the hospice p necessary documenta The interview with the at 4:15 PM. The hosp Comfort Pak form sig physician that was ree 4/15/17 was reviewed that when this form w she expected the nurs obtained a physician's DON indicated that th who was responsible with the hospice provi	ould have obtained a nospice during the ter she reviewed the FL2 int #281 received hospice the Admissions Nurse orted to the floor nurse that ospice when the admission dent #281's medical record copy) was reviewed with the ere was no physician's order ent #281. The DON stated cian's order for hospice to cord. She additionally hospice plan of care, , or hospice certification of sident #281's medical ormally the hospice provider observent to the facility vs of admission. She ed this documentation to be . The DON revealed the mentation and coordination ersight of the Admissions ported she was going to rovider to obtain the	F 526						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 05/19/2017 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345015	B. WING _			0	4/19/2017
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPPS (CONVALESCENT NH				00 MOUNTAIN TOP DRIVE SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 526	with the hospice prov A follow up interview DON on 4/18/17 at 6: documentation of a pl 4/18/17 for Resident a hospice services. Sh documentation she re hospice plan of care, the hospice certification Resident #281. The l documentation had bo #281's medical record the resident was on h	ider. was conducted with the 03 PM. She provided hysician's order dated #281's continuation of e additionally provided eceived on 4/18/17 of the hospice election form, and on of terminal illness for	F	526			

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