	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		345015	B. WING			05/24/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				500 MOUNTAIN TOP DRIVE		
CLAPP'S	CONVALESCENT NUI	RSING HOME INC		ASHEBORO, NC 27203		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	· ·	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETION DATE
F 558 SS=D		nmodations Needs/Preferences (3)	F 5	58		6/15/18
	\$492 10(a)(2) Tha	right to regide and regains				
		right to reside and receive lity with reasonable				
		resident needs and				
		t when to do so would				
		th or safety of the resident or				
-	other residents.	in or salety of the resident of				
	This REQUIREME	NT is not met as evidenced				
	by:	avious observation and		F558		
		eview, observation and			aanva aa tha	
		nterview, the facility failed to dent's need for a grab bar in		This plan of correction will		
		ill assessment for 1 of 1		facility's allegation of comp requirements of 42 CFR, P		
		eviewed (Resident #6).		Subpart B for long term cal		
		eviewed (Resident #0).		Preparation and submissio		
	1 Resident #6 was	s admitted to the facility on		correction is in response to		
		le diagnoses including Multiple		for the May 21st, 2018 surv		
		nual Minimum Data Set (MDS)		not constitute an agreemer	•	
		2/21/18 indicated that		of Clapp's Nursing Home of		
		nition was intact and she		the facts alleged or the cor		
		assistance with bed mobility.		conclusions stated on the s		
				deficiencies. This plan of c		
	On 4/4/17, Resider	nt #6 was assessed for the use		prepared and submitted be		
		assessment form revealed		requirements of 42 CFR, P		
		as using the side rail for		Subpart B throughout the ti		
		port and she had expressed a		stated in the statement of c	-	
		side rails raised in bed for		accordance with state and		
		ort. The side rails were		however, submits this plan		
		as enabler to promote		address the statement of d		
		the resident had expressed a		to serve as it's allegation of	f compliance	
		side rails while in bed.		with the pertinent requirem	-	
				dates stated in the plan of	correction and	
	On 5/22/18 at 9:30	AM, Resident #6 was		as fully completed as of 06	/15/2018.	
		She had a grab bar on the left		Key members of the Qualit	-	
		bed side table on the right side		Performance Improvement		
		I that she had requested to		met to determine the root of		
	-	the right side of her bed to		citation related to F558 as		
	holp har turned to	her right side during care.		to correct the citation. The	kov Momboro	1

(X6) DATE 06/11/2018

Electronically Signed

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.

					OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345015	B. WING		05/24/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	DE
CLAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE
F 558	Resident #6 stated th night stand to turn to feel safe and comfort had requested for the she was told that the rails in beds. On 5/22/18 at 1:47 P was interviewed. NA Resident #6. She sta needed help with turn the rail when turned of when the side rail was On 5/22/18 at 2:12 P (DON) was interview aware that Resident side rail in bed for sa informed the resident side rail in bed due to resident was not hap that Resident #6 was of the side rail when bed. On 5/24/18 at 10:10 J interviewed. She sta side rail assessment	hat she had to grab on the her right side and she didn't table. She added that she e grab bar several times but state didn't want the side M, the Nursing Aide (NA) # 7 war was assigned to ated that Resident #6 hing but she could hold on to during care and she felt safe us up in bed. M, the Director of Nursing ed. She stated that she was #6 had requested to have a fety reasons but she had t that she could not have a o entrapment issue and the py about it. The DON added a not assessed for the need it was removed from her AM, the Administrator was ted that she agreed that a	F 55	included the Administrator, D Nursing and MDS Coordinato Committee determined there misunderstanding among pre- employed facility management the new side rail regulations. had, and always will have, the abide by all regulations and h resident's rights, while also a keep residents safe while in or Resident #6, a side rail assess completed on 06/12/2018 by Manager and was assessed using the left side rail only. The the side rail assessments we with Resident #6 on 06/12/20 to be in substantial compliano all Nurses and CNAs from all well as all facility managers w in-serviced by the Director of the correct intent of the new r made by the state, including all residents have the right to for side rails. This in-service w complete on 06/08/2018. The also complete side rail assess current residents. These asses be completed collaboratively Therapy Department and the Managers by 06/13/2018. A r side rail assessment will also be r resident/responsible party, wi applicable. All long-term reside re-assessed for side rails qua- needed if the resident's cond by the Minimal Data Set Coord is the Minimal Data Set Coord	by the service of the results of reviewed with hichever dents will be arterly and as ition changes

Event ID: 4GCC11

Facility ID: 923103

If continuation sheet Page 2 of 68

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345015	B. WING		05/24/2018
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	•
			5	500 MOUNTAIN TOP DRIVE	
LAPP 5	CONVALESCENT NUI	RSING HOME INC	A	ASHEBORO, NC 27203	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIC
F 558	Continued From pa	age 2	F 558		on ns the er d l apist ance l be bund ill e l y ng is
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(F 561		6/15/18

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-039
-	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345015	B. WING		05/24/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CLAPP'S	CONVALESCENT NURSI	NG HOME INC		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 561	Continued From page	23	F 56	1	
	promote and facilitate through support of res not limited to the right (1) through (11) of this §483.10(f)(1) The res activities, schedules (waking times), health care services consiste assessments, and pla applicable provisions §483.10(f)(2) The res choices about aspect facility that are signifie §483.10(f)(3) The res with members of the community activities to facility. §483.10(f)(8) The res participate in other activities participate in other activities participate in other activities. Based on record revis staff interview, the fact residents' choices by cognitively intact resid desire to have side rational staff and the staff and the staff and the community activities of the staff and the participate in other activities of the staff and the staff interview, the fact residents' choices by cognitively intact resid	right to and the facility must a resident self-determination sident choice, including but its specified in paragraphs (f) is section. ident has a right to choose including sleeping and care and providers of health ent with his or her interests, an of care and other of this part. ident has a right to make is of his or her life in the cant to the resident. ident has a right to interact community and participate in both inside and outside the ident has a right to trivities, including social, nity activities that do not ts of other residents in the is not met as evidenced ew, resident interview, and		F561 This plan of correction will serve as the facility's allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this pla correction is in response to DHHS 256 for the May 21st, 2018 survey and doe	n of 7

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Facility ID: 923103

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUITIP	LE CONSTRUCTION	(X3) DATE SURVE	8-03 -	
	CORRECTION	IDENTIFICATION NUMBER:	· /		COMPLETED		
		345015	B. WING		05/24/20	05/24/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
CLAPP'S	CONVALESCENT NURS	ING HOME INC	500 MOUNTAIN TOP DRIVE 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COM	(X5) PLETIC DATE	
F 561	Continued From page	e 4	F 56	1			
	The findings included	1:		not constitute an agreemer	nt or admission		
				of Clapp's Nursing Home of	of the truth of		
		admitted to the facility on		the facts alleged or the cor			
		diagnoses that included		conclusions stated on the s			
	Parkinson 's Disease	9.		deficiencies. This plan of o			
	The quarterly Minimu	um Data Set (MDS)		prepared and submitted be requirements of 42 CFR, P			
		11/18 indicated Resident		Subpart B throughout the t			
		intact. She was assessed		stated in the statement of c			
	-	ed assistance of 1 staff for		accordance with state and	federal law,		
	bed mobility and tran	sfers. She had no		however, submits this plan	of correction to		
	impairment with rang	e of motion.		address the statement of d			
				to serve as it's allegation o	-		
		Resident #15, dated 3/11/18,		with the pertinent requirem			
		deficit requiring the limited the bed mobility and with		dates stated in the plan of			
	transfers at times.	In bed mobility and with		as fully completed as of 06 Key members of the QAPI			
				to determine the root cause			
	An interview was cor	ducted with Resident #15		related to F561 as well as			
	during the Resident (Council Meeting held on		correct the citation. The Co			
	5/22/18 beginning at	2:00 PM. She indicated a		determined there had beer	na		
		moval of her side rails. She		misunderstanding among p			
		had been removed several		employed facility managen			
		her expressed desire to have		the new side rail regulation			
		to assist with positioning. ed when her side rails were		had, and always will have, abide by all regulations and			
		d not addressed her desire		resident's rights, while also			
		and they also had not		keep residents safe while i			
		e risks and benefits of side		Resident #10, #12, #15 an			
	rail usage.			assessments were comple			
				to 06/12/2018 by the Unit M			
		ducted with the Director of		Therapist. The results of th			
		22/18 at 10:52 AM. The		assessments were reviewe			
		e beginning of 2017 most		resident or responsible par	-		
		y had side rails. She stated		06/12/2018. In order to be			
		ally began removing side sage between March 2017		compliance with F558, all CNAs from all shifts as we			
		She reported that side rail		managers were in-serviced	-		
		have been completed prior		Director of Nursing on the			

Facility ID: 923103

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		MEDICAID SERVICES					O. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	1 Y /	E SURVEY IPLETED
		345015	B. WING			05	5/24/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC			00 MOUNTAIN TOP DRIVE SHEBORO, NC 27203		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETIC
F 561	Continued From page	e 5	F 5	61			
		side rails to determine the			the new regulations made by the state	.	
	need for the side rails			including the fact that all residents have			
	the risks and benefits			the right to be assessed for side rails.			
	an alternative interve			in-service was complete on 06/08/201	8.		
		de rail assessments had not			The facility will also complete side rail		
	been completed for a			assessments on all current residents.			
	side rails removed.			These assessments will be completed			
		ical record and the most			collaboratively by the Therapy Depart		
		sment completed was dated ed this assessment indicated			and the Nurse Managers by 06/13/20 review of the side rail assessment and		
	Resident #15 express			results of this assessment will also be			
	rails raised while in b			reviewed with resident/responsible pa			
	additionally indicated			whichever applicable. All long-term	,		
	-	to serve as an enabler to			residents will be re-assessed for side	rails	
	promote independent	ce. The DON confirmed the			quarterly and as needed if the residen	ťs	
		t #15 had been removed, no			condition changes by the Minimal Dat		
		was completed prior to their			Set Coordinator. All new admissions v		
		n on the risks and benefits			have a side rail assessment complete	-	
	-	s provided to the resident,			a Therapist upon admission to the fac		
	and no alternative int	ervention was implemented.			All Nurse Managers and Therapists w		
	An interview was con	ducted with the			in-serviced by the Director of Nursing	on	
		1/18 at 10:10 AM. The			this new protocol by 06/08/2018. In order to ensure the facility's solution	16	
		that side rail assessments			are sustained and that substantial	15	
		mpleted prior to the removal			compliance with F561 continues, 5		
	of the side rails.				residents will be randomly chosen by	the	
					Director of Nursing or Administrator pe		
		admitted to the facility on			week x 5 weeks. These 5 resident's		
	-	s that included cerebral			medical records will be audited to ens	ure	
		etes Mellitus, and restless			a side rail assessment has been		
	leg syndrome.				completed and documentation is note	a	
		m Data Sat (MDS)			within the record stating the		
	The quarterly Minimu	27/18 indicated Resident			resident/responsible party has been educated on our side rail assessment		
		fully intact. He required the			protocol and the results of this		
	-	of 2 or more staff with bed			assessment. If the resident is newly		
		s. He had no impairment			admitted, the Director of Nursing or		
	with range of motion.	-			Administrator is to ensure the side rail		
	_				assessment was completed by a thera		1

Facility ID: 923103

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		ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 07/03/2018 RM APPROVED IO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION		FE SURVEY MPLETED
		345015	B. WING _			5/24/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		0/24/2010
				500 MOUNTAIN TOP DRIVE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC		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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 561	included a self-care of assistance of 1-2 star transfers. An interview was con during the Resident of 5/22/18 beginning at concern about the real stated his side rails h months ago despite h side rails on his bed. when his side rails we not addressed his de and they also had no risks and benefits of star	Resident #10, dated 2/28/18, deficit requiring the extensive ff with bed mobility and ducted with Resident #10 Council Meeting held on 2:00 PM. He indicated a moval of his side rails. He ad been removed several his expressed desire to have Resident #10 indicated ere removed the staff had sire to keep the side rails t discussed with him the side rail usage.	F 5	61 upon admission. If substa is found during this audit, reduced to 5 residents per months. If substantial com during the monthly audits, then be discontinued. This followed by the Quality As Performance Improvemen and discussed in the bi-we QAPI meetings. The Direct responsible for presenting correction to the QAPI con areas of concern found wi upon discovery by the app committee members.	the audit will be r month x 3 ppliance is found the audit will s audit will be surance at Committee eekly/monthly ctor of Nursing is the plan of mmittee. Any ill be addressed	
	DON stated that at the residents in the facilit that the facility gradue rails to reduce their u and October 2017. S assessments should to the removal of the need for the side rails the risks and benefits an alternative interve She stated she review record and the most completed was dated assessment indicated desire to have side ra assessment additionar recommendation was enabler to promote in confirmed the side ra	22/18 at 10:52 AM. The the beginning of 2017 most by had side rails. She stated ally began removing side sage between March 2017 She reported that side rail have been completed prior side rails to determine the s, to provide education on a of side rails, and to provide ntion if deemed necessary. wed Resident #10 's medical recent side rail assessment 1 4/3/17. She reported this d Resident #10 expressed a ails raised while in bed. This ally indicated the s for side rails to serve as an independence. The DON ils for Resident #10 had de rail assessment was solute				

CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE		FORM	D: 07/03/2018 APPROVED D: 0938-0391 SURVEY
AND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMP	LETED
		345015	B. WING			05/	24/2018
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURSI	NG HOME INC			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	completed prior to the the risks and benefits provided to the reside intervention was imple An interview was com Administrator on 5/24 Administrator stated t should have been cor of the side rails. 3. Resident #12 was a 1/19/16 with diagnose osteoporosis, adult fa and age-related debil The quarterly Minimu assessment dated 2/2 #12 's cognition was the extensive assistan bed mobility and 1 sta no impairment with ra The plan of care for R included a self-care d assistance of staff wit An interview was com during the Resident C 5/22/18 beginning at 2 concern about the rer stated her side rails h months ago despite h side rails on her bed. when her side rails we not addressed her de	eir removal, no education on of side rail usage was ent, and no alternative emented. ducted with the /18 at 10:10 AM. The hat side rail assessments mpleted prior to the removal admitted to the facility on es that included ilure to thrive, weakness, ity. m Data Set (MDS) 28/18 indicated Resident fully intact. She required nce of 2 or more staff with aff with transfers. She had unge of motion. Resident #12, dated 2/28/18, leficit requiring the extensive th bed mobility and transfers. ducted with Resident #12 council Meeting held on 2:00 PM. She indicated a moval of her side rails. She iad been removed several her expressed desire to have Resident #12 indicated ere removed the staff had sire to keep the side rails t discussed with her the risks	F	561			

Facility ID: 923103

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	S FOR MEDICARE &		0.00			10.0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY MPLETED	
		345015	B. WING		05/24/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•		
CLAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 561	Continued From page	2 8	F 56	51			
		ducted with the Director of	1.00				
		22/18 at 10:52 AM. The					
	• • •	e beginning of 2017 most					
		y had side rails. She stated					
		ally began removing side					
		sage between March 2017					
		She reported that side rail have been completed prior					
		side rails to determine the					
		s, to provide education on					
		of side rails, and to provide					
	an alternative interve	ntion if deemed necessary.					
		wed Resident #12 's medical					
		recent side rail assessment					
		3/31/17. She reported this Resident #12 expressed a					
		ails raised while in bed. The					
	assessment additiona						
	recommendation was	for bilateral side rails to					
		o promote independence					
		edical conditions/symptoms					
		veakness. The DON ils for Resident #12 had					
		de rail assessment was					
	,	eir removal, no education on					
		of side rail usage was					
		ent, and no alternative					
	intervention was impl	emented.					
	An interview was con	ducted with the					
		/18 at 10:10 AM. The					
		that side rail assessments					
	of the side rails.	mpleted prior to the removal					
		admitted to the facility on					
	3/30/17 and most rec	ently readmitted on 1/28/18					
		ncluded Traumatic Brain plegia (paralysis of one side					

Facility ID: 923103

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		MEDICAID SERVICES	(X2) MUITIPI F	CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	IPLETED
		345015	B. WING		05	5/24/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC		00 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 561	1.5		F 561			
	of the body) affecting	the left dominant side.				
	The annual Minimum Data Set (MDS) assessment dated 4/3/18 indicated Resident #37 's cognition was intact. He required the extensive assistance of 2 or more staff for bed					
		endent on 2 or more staff for pairment on both sides of extremities.				
	included a self-care of	Resident #37, dated 4/3/18, leficit requiring the extensive staff with personal care and				
	during the Resident 0 5/22/18 beginning at concern about the re- stated his side rails h months ago despite h	ducted with Resident #37 Council Meeting held on 2:00 PM. He indicated a moval of his side rails. He ad been removed several his expressed desire to have Resident #37 indicated				
	when his side rails we not addressed his de	ere removed the staff had sire to keep the side rails t discussed with him the				
	Nursing (DON) on 5/2 DON stated that at th residents in the facilit that the facility gradu	ducted with the Director of 22/18 at 10:52 AM. The le beginning of 2017 most y had side rails. She stated ally began removing side sage between March 2017				
	and October 2017. assessments should to the removal of the	She reported that side rail have been completed prior side rails to determine the s, to provide education on				

Facility ID: 923103

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(X3) DATE SURVEY COMPLETED	
05/24/2018	
· · · · · · · · · · · · · · · · · · ·	
CTION (X5) DULD BE COMPLETIO ROPRIATE DATE	
6/15/18	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/03/2018 APPROVED D: 0938-0391
STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345015	B. WING			05/	24/2018
NAME OF PROV	IDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S CO	NVALESCENT NURSI	NG HOME INC			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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
re (iv) re th gr (A re (E fa re §4 pa §4 fa re fa r fa r	 a) The facility must of sident or family group e grievances and recours concerning issent the facility. b) The facility must is sponse and rational by This should not be cility must implement quest of the resider 483.10(f)(6) The resent facility must implement for the resider facility must implement quest of the resider 483.10(f)(7) The resent facility member(s) or concent for the facility member(s) or concent for the facility in the facility is REQUIREMENT or ased on review of the residents and staff, the respond to concent sidents who regular eetings (Residents in concent for the findings included A resident council 22/18 at 2:00 PM. The result of the facility is reported due to the respond to concent for the findings included A resident council 22/18 at 2:00 PM. The result of the facility for the findings included the findings. Multiple growth document for the facility at 2:00 PM. The findings included the findings. Multiple growth document for the facility at 2:00 PM. The findings included the findings. Multiple growth document for the findings. 	om group meetings. consider the views of a up and act promptly upon commendations of such sues of resident care and life be able to demonstrate their le for such response. e construed to mean that the nt as recommended every at or family group. ident has a right to roups. ident has a right to have other resident et in the facility with the opresentative(s) of other y. i is not met as evidenced the resident council meeting w, and interviews with the facility failed to document erns for 5 of 10 sampled ty attended resident council #6, #10, #12, #15, and #37).	F	565	F565 This plan of correction will serve as the facility's allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this pla correction is in response to DHHS 256 for the May 21st, 2018 survey and doe not constitute an agreement or admiss of Clapp's Nursing Home of the truth of the facts alleged or the correctness of conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the	an of 57 es sion of the f	

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		MEDICAID SERVICES			OMB NO. 0938-
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345015	B. WING		05/24/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE
CLAPP'S	CONVALESCENT NURS	ING HOME INC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLI TO THE APPROPRIATE DAT
F 565	Continued From pag	e 12	F 56	35	
		al of their side rails that		stated in the statement	of deficiencies In
		f 2017. The residents stated		accordance with state a	
		concern during more than		however, submits this p	-
		meeting, all unable to recall		address the statement of	
		his was brought up, and		to serve as it's allegation	n of compliance
	were provided with n	o follow up and/or resolution.		with the pertinent require	
				dates stated in the plan	
		cted of the resident council		as fully completed as of	
		ed 11/1/17, 12/6/17, 1/3/18,		Key members of the QA	
		3, and 5/2/18. There was no		to determine the root ca	
	the resident council r	erns related to side rails in		related to F565 as well a correct the citation. The	
		neeting minutes.		determined there had be	
	1a. Resident #15 wa	s identified as alert and		misunderstanding amon	
		sident of the resident council.		employed facility manage	
	-	um Data Set assessment		the new side rail regulat	
	dated 3/11/18 indicat	ed Resident #15 's cognition		the Social Worker was u	under the
	was intact.			impression there was no	o action that could
				be taken related to the o	
		ent council minutes indicated		5 of the 10 sampled res	
	Resident #15 had att			residents affected, Resi	
	resident council mee	tings.		#15 and #37, a formal g	
	During the regident of	ouncil monting on 5/22/19 at		written on 06/08/2018 fo	
	-	council meeting on 5/22/18 at		and the facility's grievan followed accordingly by	-
		removal of her side rails		Worker. In order to achi	
		e resident council meeting		compliance with F565, t	
	-	th no follow up and/or		along with all other Man	
	resolution.	·		LPNs and all Therapists	
				by the Director of Nursir	ng on the correct
		s identified as alert and		intent of the new regulat	-
		ar attendee of the resident		state, including the fact	
	-	ly Minimum Data Set		have the right to be asso	
		28/18 indicated Resident		rails. This in-service was 06/08/2018. The Social	
	#12 's cognition was	o midGl.		educated by the Directo	
	A review of the residu	ent council minutes indicated		06/05/2018 related to th	-
	Resident #12 had at			following the facility's gr	
	resident council mee			procedure no matter wh	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		NO: 0938-039 DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	, í	3	· · ·	COMPLETED
		345015	B. WING			05/24/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	P CODE	
CLAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 565	Continued From page	e 13	F 56	65		
	During the resident c	ouncil meeting on 5/22/18 at		voiced by the resident m	ay be.	
	2:00 PM Resident #1 her concern with the during more than one	2 indicated she had reported removal of her side rails e resident council meeting th no follow up and/or		To ensure substantial co F565 continues, the DOI will ask to be invited to th resident council meeting months. Permitting the re DON or designee to part	N or Administrator ne monthly for the next 3 esidents allow the	
	oriented and a regula council. The quarter	18/18 indicated Resident #6		meetings, the DON or de observe the meeting and concerns voiced. Within resident council meeting Administrator will review	esignee will I note any 24 hours of the , the DON or the meeting	
	Resident #6 had atte council meetings.	ent council minutes indicated nded 4 of the last 7 resident		minutes and the facility g ensure all concerns obse on the meeting minutes a concerns are being activ per the facility's grievanc	erved were noted and that all rely addressed, re policy and	
	2:00 PM Resident #6 her concern with the during more than one	ouncil meeting on 5/22/18 at indicated she had reported removal of her side rails e resident council meeting th no follow up and/or		procedure. If substantial found after the monthly a Administrator will then as one meeting per quarter ensure on-going complia	audit, the DON or sk to be invited to for 1 year to	
	resolution. 1d. Resident #37 wa oriented and a regula council. The annual	s identified as alert and ar attendee of the resident Minimum Data Set 3/18 indicated Resident #37		compliance is found afte the meeting one quarter the audit will be discontir and the plan of correction by the facility's QAPI Con results of this audit will b the bi-weekly/monthly me	r participating in out of the year, nued. This citation n will be followed mmittee and e discussed in eetings and as	
	Resident #37 had att resident council mee	tings.		needed. The Director of responsible for presentin correction to the QAPI co areas of concern will be immediately with the con	ng this plan of committee. Any addressed	
	2:00 PM Resident #3 his concern with the	ouncil meeting on 5/22/18 at 7 indicated he had reported removal of his side rails e resident council meeting		appropriate members.		

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	MENT OF HEALTH AN						FORM): 07/03/2018 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE	
		345015	B. WING				05/	24/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP COD	E		
CLAPP'S	CONVALESCENT NURSI	NG HOME INC			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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 565	Continued From page	e 14	F	565				
	and was provided with resolution.	n no follow up and/or						
	oriented and a regula council. The quarterly	27/18 indicated Resident						
	A review of the reside Resident #10 had atte resident council meet							
	2:00 PM Resident #10 his concern with the r	ouncil meeting on 5/22/18 at D indicated he had reported emoval of his side rails resident council meeting n no follow up and/or						
	Worker (SW) on 5/22, indicated she was res the resident council m meetings, ensuring th were documented, an during the meetings w stated she was aware members of the residu bringing up a concern side rails on more tha revealed she had not minutes and had not The SW explained tha rails were not allowed so she thought nothin	ponsible for coordinating neetings, attending the e minutes for the meetings d that concerns reported vere followed up on. She e of at least of one of the ent council (Resident #6) regarding the removal of						

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345015	B. WING		05/24/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL	DE
	CONVALESCENT NURS			500 MOUNTAIN TOP DRIVE	
CLAFF 3	CONVALESCENT NORS			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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 565	Continued From page	e 15	F 5	65	
		in the facility had their side			
		I months ago in an effort to			
		age. She reported she was			
	aware of some reside				
	• •	al of side rails, but was n had been discussed in the			
		e indicated she expected the			
		tes to accurately reflect the			
		ns and concerns and for the			
	concerns to be follow	-			
F 600		-	F 6	00	6/15/18
SS=G	CFR(s): 483.12(a)(1)				
	\$483.12 Freedom fro	m Abuse, Neglect, and			
	Exploitation				
	The resident has the	right to be free from abuse,			
		ation of resident property,			
	•	efined in this subpart. This			
	includes but is not lim	involuntary seclusion and			
		ical restraint not required to			
	treat the resident's m				
	§483.12(a) The facilit	y must-			
	§483.12(a)(1) Not us physical abuse, corpo	e verbal, mental, sexual, or			
	involuntary seclusion				
	by:	וש הטו וווכו מש לאועלוונכע			
	Based on record rev	iew, resident interview, and		F600	
		cility neglected to implement		This plan of correction will se	
		on related to falls that		facility's allegation of complia	
	the bathroom when s	28 was not to be left alone in he was assisted with		requirements of 42 CFR, Par Subpart B for long term care	
		28 was assisted to the		Preparation and submission	
	•	Assistant (NA) #1, NA #1		correction is in response to D	•
	. 0	· · ·			

L

Event ID: 4GCC11

Facility ID: 923103

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					OMB NO.	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE S COMPL	
		345015	B. WING		05/2	4/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP CODE	
CLAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE 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 (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 600	Continued From page	e 16	F 60	00		
	 Continued From page 16 resident 's room, and Resident #28 fell as she attempted to transfer independently from the toilet to her wheelchair while unattended by staff. The fall resulted in Resident #28 sustaining a subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain) and a subdural hematoma (pool of blood between the brain and its outermost covering). This was for 1 of 1 residents reviewed for neglect. Resident #28 was admitted to the facility on 11/21/17 and readmitted on 1/5/18 with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), adult failure to thrive, age related debility, weakness, and difficulty in walking. The admission Minimum Data Set (MDS) assessment dated 1/12/18 indicated Resident 			constitute an agreement Clapp's Nursing Center of facts alleged or the correc conclusions stated on th deficiencies. This plan of prepared and submitted requirements of 42 CFR Subpart B throughout the stated in the statement of accordance with state an however, submits this pl address the statement of to serve as it's allegation with the pertinent require dates stated in the plan as fully completed as of Key members of the QA to determine the root can related to F600. The cor determined the care plan	of the truth of the ectness of the le statement of of correction is because of the determined by the period of deficiencies. In and federal law, lan of correction to of deficiencies and of compliance ements as of the of correction and 06/15/2018. PI committee met use of the citation mmittee	
	#28 's cognition was behaviors and no reje- required the extensiv- staff with bed mobility assistance of 1 staff f personal hygiene. St assistance of 1 staff f was not steady on he stabilize without staff wheelchair and walke with her range of mot	fully intact. She had no ection of care. Resident #28 e assistance of 2 or more y and the extensive for toileting, dressing, and he required the limited for transfers. Resident #28 er feet, but she was able to assistance. She utilized a er and had no impairment ion. Resident #28 was		inaccurately addressed needs at the time of the committee also determin such as fall interventions are responsible for were in the care plan in such CNAs were able to see t kiosks. To minimize risk having further accidents was updated correctly so tasks and responsibilitie	the resident's fall. The ned that tasks, s, which the CNAs e not being layered a way that the the tasks on their of Resident #28 , the care plan o that the CNA's s, including fall	
	The Care Area Asses Activities of Daily Livi s 1/12/18 MDS indica extensive assistance	t of bladder and bowel. sment (CAA) related to ng (ADLs) for Resident #28 ' ited she required limited to of 1 staff with ADLs related weakness, and balance		interventions, would sho care plan for the CNA's to to view this information a to know specifically the a resident needs during to Specific interventions wh implemented since resid	to see. Being able allows the CNA's assistance illeting tasks. hich have been	

Facility ID: 923103

		MEDICAID SERVICES					D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		345015	B. WING			05	24/2018
NAME OF P	ROVIDER OR SUPPLIER	-		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC	500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 600	Continued From pag	e 17	F 60	0			
		related to falls for Resident	1 00		03/01/2018 and to minimize risk of fall	9	
	#28 ' s 1/12/18 MDS			include: Resident given non-skid sock	-		
	falls with injury.			and educated on the importance of	-		
				wearing them and education provided	on		
	Resident #28 ' s plar	of care included the focus			not attempted to transfer from any sur		
	area of the potential	for falls. This area was			without assistance.		
	initiated on 11/28/17	and reviewed on 1/12/18.			The Task Care plan was updated on		
		luded, in part, "Staff to			05/23/2018 to reflect all appropriate fa		
	-	ileting task if assisted to			interventions for Resident #28. All cur		
		back to chair/bed. Do not			charts of residents with fall intervention	ns	
	leave me alone in ba	throom."			in place were audited by the MDS		
				Consultants prior to 06/15/2018 to ens	sure		
	A review was conduct			the interventions which CNAs were	d		
	for Resident #28 ' s t through 3/1/18. The			responsible for were both accurate an viewable by the CNA. Also prior to	u		
		I of required assistance for			06/15/2018, the Director of Nursing ar	hd	
	toileting varied from t			MDS Coordinator completed a full auc			
	staff to total depende			all physical fall interventions and verifi the physical interventions were in place	ed		
	An incident report da	ted 3/1/18 and written by			The facility has now initiated a new		
	Nurse #1 indicated R	Resident #28 had an			process for entering CNA tasks into th	е	
		injury on 3/1/18 at 8:15 AM.			care plan in order for the CNA to be al	ble	
		ries were noted as, "skin tear			to see their required tasks/duties. All		
		edness, hematoma". Nurse			nurses and CNAs will be re-educated	on	
		ident #28 's bathroom by			where to view the task care plan by		
		had fallen from the toilet onto			06/15/2018 by DON or Unit Manager.		
		attempting to transfer into			They were also educated that		
		ident #28 was noted to have			interventions in which CNAs are		
		o the left elbow and one to kin tears were cleaned and			responsible for will be viewable on the task care plan so the CNA can view th		
		k was applied to Resident			care planned interventions every shift.		
		as assisted back to her			The facility has created a QAPI audit f		
	wheelchair by 2 staff				monitoring the fall interventions listed		
	Responsible Party (F				the resident's care plan, task care plan		
					and are being followed as written. Due		
	The Fall Scene Inves	stigation (FSI) Report related			the citation and in order to ensure		
		all on 3/1/18 at 8:15 AM			compliance on-going, 5 Care Plans wi	ll be	
		the first staff present			audited per week x 4 weeks by the		
	following Resident #2	28 ' s unwitnessed fall.			Director of Nursing to ensure proper fa	all	1

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		ND HUMAN SERVICES			PRINTED: 07/03/2018 FORM APPROVED
STATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		345015	B. WING		05/24/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
				500 MOUNTAIN TOP DRIVE	
CLAPP'S	CONVALESCENT NURS	ING HOME INC		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 600	Resident #28 was fou bathroom after attem Resident #28 was as prior to the fall. She transfer to her wheeld provided a written sta indicated Resident #2 3/1/18 around 7:50 A light and proceeded the her bathing and dress Resident #28 to her to Resident #28 to her to Resident #28 to her to Resident #28 to her to Resident #28 to her to the bathing and dress Resident #28 to her to Resident #28 to her to the bathroom to pick-up to and linens from the fli indicated while she w she heard Resident # Resident #28 had not assistance and she h #1 indicated she rem the call light for assis A nursing note dated #1 confirmed the info dated 3/1/18. The not Resident #28 had but and neurological assess A physician ' s order of neurological assess Resident #28 ' s cond	und on the floor in her pting to self-transfer. sessed as alert and oriented stated she was trying to chair. The FSI Report atement from NA #1. NA #1 28 pressed her call light on M. NA #1 answered the call to assist Resident #28 with sing. She then assisted bathroom (located inside of room). NA #1 reported that rred Resident #28 from her et she had stepped out of the the resident 's nightgown oor in her room. NA #1 vas outside of the bathroom #28 scream. She noted that t called out verbally for her had not rang the call bell. NA inded Resident #28 to use tance in the bathroom. 3/1/18 and written by Nurse rmation in the incident report of additionally indicated mped her head on the floor essments were initiated. dated 3/1/18 indicated hents for Resident #28. ted of the neurological B/1/18 beginning at 8:30 AM. indicated no concerns with dition through the ed on 3/1/18 at 11:30 AM.	F 60	interventions are listed on the resise care plan, task care plan, and any physical interventions are in place substantial compliance is found, the will be reduced to 2 Care Plans performed to a compliance of the QAPI committee will review the and determine the frequency of the going forward. Also to ensure on-ecompliance, the unit managers or of nursing will observe 5 CNA's perfor 4 weeks during one toileting the ensure care planned interventions being followed by CNA. If substant compliance is found during the weaudit, the audit will then be reduced CNAs monthly for 3 months. These will be completed on all shifts as wo on weekends. If substantial comp continues to be found during the raudit, spot checks will continue by managers on an on-going basis. To QAPI committee will discuss the properties of the bi-weekly/monthly meetings a often if needed. The Director of N will be responsible for presenting of correction to the QAPI committee accordingly by the appropriate commembers.	y e. If the audit er month complete he audits going director er week ask to s are htial eekly ed to 5 se audits well as bliance monthly y unit The progress tion in und more lursing this plan tee. Any ed

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CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	ECONSTRUCTION		FORM	0: 07/03/2018 APPROVED 0: 0938-0391 SURVEY
AND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			COMP	LETED
		345015	B. WING				05/	24/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	E		
CLAPP'S	CONVALESCENT NURSI	NG HOME INC			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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BI		(X5) COMPLETION DATE
F 600	indicated Nurse #1 wa room. Resident #28 f shaking. She stated f t feel good. The phys order was received to Emergency Room (Ef The ER records indica in the Emergency Dep neurology consultatio presented with a trau Hemorrhage (SAH) or (computerized tomogis suspected Subdural F admitted to the hospit and monitoring. This was discussed wheth appropriate on neurol service, but medicine comfortable managing s bleed. The hospital #28 remained in the h 3/5/18 when she was facility. Resident #28 ' s plan updated on 3/5/18 wit intervention, "Do not I bathroom." This was was previously in place A physician ' s progree indicated Resident #22 facility following a hos in closed head trauma	as called to Resident #28 ' s had vomited and was her head hurt and she didn ' sician was notified and an o send Resident #28 to the R) for evaluation. ated Resident #28 was seen partment on 3/1/18 and a n was ordered. The n indicated Resident #28 matic Subarachnoid n the right side. A head CT raphy) scan showed Hematoma (SDH). She was tal for repeat CT head scans consultation noted that it er Resident #28 was more logy service or medicine service had not felt g the size of Resident #28 ' records indicated Resident nospital from 3/1/18 through discharged back to the of care related to falls was th the handwritten leave Resident alone in a duplicate intervention as it ce on the care plan. ass note dated 3/28/18 28 was readmitted to the spital stay for a fall resulting	F	600				

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 07/03/2018 DRM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) D.	ATE SURVEY DMPLETED
		345015	B. WING				05/24/2018
NAME OF PI	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
CLAPP'S	CONVALESCENT NURS	ING HOME INC			0 MOUNTAIN TOP DRIVE		
				A	SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 600	A review of the medic #28 has returned to h The NA Daily Care G #28 was reviewed on for Resident #28 inclu monitor me during toi bathroomtransfer b leave me alone in bat An interview was con 5/22/18 at 3:05 PM. interventions on the c NA Daily Care Guide the intervention was in then it was also in pla Guide. The intervent indicated, "Staff to me task if assisted to bat chair/bed. Do not leav was reviewed with the intervention was in pla	cal record indicated Resident her baseline health status. uide, undated, for Resident 5/22/18. The interventions uded, in part, "Staff to leting task if assisted to back to chair/bed. Do not	F	600			
	5/22/18 at 2:25 PM. at the facility for about familiar with Resident Resident #28 was a f falls. She confirmed Resident #28 on 3/1/ AM fall. She stated s to the bathroom after bathing. NA #1 indica Resident #28 to the to bathroom during the f changed Resident #2	all risk and she had several she was working with 18 at the time of her 8:15 he had taken Resident #28 she assisted her with					

Facility ID: 923103

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				OMB NO. 0938		
	IDENTIFICATION NUMBER:	. ,		COMPLETED	I	
	345015	B. WING		05/24/201	18	
OVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE			
ONVALESCENT NURS	ING HOME INC					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE COMPL	X5) PLETIO ATE	
and back to her whee to retrieve a roll of tra Resident #28 's room out of the bathroom fi she heard Resident # the bathroom, and sh #1 confirmed that Re attempting to self-tran This interview with N, asked how she was r interventions that we NA kiosk, an electron Care Guide, had a lis for each resident. Th #28 was reviewed wi included the intervent during toileting task if transfer back to cha alone in bathroom." had assisted Resider left her alone while sh resident 's room. She known this interventiof #28. She reported th was able to toilet inde needed assistance ch An interview was con 5/23/18 at 9:06 AM. at the facility for over familiar with Resident Resident #28 was a f	elchair, she left the bathroom ash bags she had left in n. She indicated she was or about 5 seconds when 28 scream, she re-entered he found her on the floor. NA sident #28 had fallen while insfer without staff present. A #1 continued. She was made aware of fall risk re in place. She stated the hic record of the NA Daily st of all of the interventions he NA kiosk for Resident th NA #1. The kiosk tion, "Staff to monitor me f assisted to bathroom air/bed. Do not leave me NA #1 acknowledged she ht #28 to the bathroom and he retrieved items from the e revealed she had not on was in place for Resident that she thought Resident #28 ependently and that she only hanging her brief.	F 600				
	DVIDER OR SUPPLIER ONVALESCENT NURS SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page and back to her whee to retrieve a roll of tra Resident #28 's roor out of the bathroom f she heard Resident # the bathroom, and sh #1 confirmed that Re attempting to self-tra This interview with N. asked how she was r interventions that we NA kiosk, an electror Care Guide, had a lis for each resident. T #28 was reviewed wi included the interven during toileting task if transfer back to cha alone in bathroom." had assisted Resider left her alone while sl resident 's room. She known this intervent #28. She reported th was able to toilet inder needed assistance cl An interview was cor 5/23/18 at 9:06 AM. at the facility for over familiar with Residen Resident #28 was a f	CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345015 DVIDER OR SUPPLIER ONVALESCENT NURSING HOME INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 and back to her wheelchair, she left the bathroom to retrieve a roll of trash bags she had left in Resident #28 's room. She indicated she was out of the bathroom for about 5 seconds when she heard Resident #28 scream, she re-entered the bathroom, and she found her on the floor. NA #1 confirmed that Resident #28 had fallen while attempting to self-transfer without staff present. This interview with NA #1 continued. She was asked how she was made aware of fall risk interventions that were in place. She stated the NA kiosk, an electronic record of the NA Daily Care Guide, had a list of all of the interventions for each resident. The NA kiosk for Resident #28 was reviewed with NA #1. The kiosk included the intervention, "Staff to monitor me during toileting task if assisted to bathroom transfer back to chair/bed. Do not leave me alone in bathroom." NA #1 acknowledged she had assisted Resident #28 to the bathroom and left her alone while she retrieved items from the resident 's room. She revealed she had not known this intervention was in place for Resident #28. She reported that she thought Resident #28 was able to toilet independently and that she only needed assistance changing her brief. An interview was conducted with Nurse #1 on 5/23/18 at 9:06 AM. She stated she had worked at the facility for over 11 years and she was familiar with Resident #28. She reported Resident	IDENTIFICATION NUMBER: A. BUILDING. 345015 B. WING OVALESCENT NURSING HOME INC ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 21 and back to her wheelchair, she left the bathroom to retrieve a roll of trash bags she had left in Resident #28 's room. She indicated she was out of the bathroom for about 5 seconds when she heard Resident #28 scream, she re-entered the bathroom, and she found her on the floor. NA #1 confirmed that Resident #28 had fallen while attempting to self-transfer without staff present. This interview with NA #1 continued. She was asked how she was made aware of fall risk interventions that were in place. She stated the NA kiosk, an electronic record of the NA Daily Care Guide, had a list of all of the interventions for each resident. The NA kiosk for Resident #28 was reviewed with NA #1. The kiosk included the intervention, "Staff to monitor me during toileting task if assisted to bathroom transfer back to chair/bed. Do not leave me alone in bathroom." NA #1 acknowledged she had assisted Resident #28 to the bathroom and left her alone while she retrieved items from the resident 's room. She revealed she had not known this intervention was in place for Resident #28. She reported that she thought Resident #28 was able to toilet independently and that she only needed assistance changing her brief. An interview was conducted with Nurse #1 on 5/23/18 at 9:06 AM. She stated she had worked at the facility for over 11 years and she was familiar with Resident #28. She reported Resident #28 was a fall risk and she had several	Contraction (X1) PROVIDERSUPPLERCLAN (X2) MULTIPLE CONSTRUCTION ABOUT A BUILDING JUDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZP CODE SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDERS PLAN OF CORRECT (EACH CORRECT ADDRESS, CITY, STATE, ZP CODE S0 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203 Continued From page 21 and back to her wheelchair, she left the bathroom to retrieve a roll of trash bags she had left in Resident #28' s room. She indicated she was out of the bathroom for about 5 seconds when she heard Resident #28 had fallen while attempting to self-transfer without staff present. F 600 This interview with NA #1 continued. She was asked how she was made aware of fall risk interventions that were in place. She stated the NA kiosk, an electronic record of the NA Daily Care Guide, had a list of all of the interventions for each resident. The NA kiosk for Resident #28 was reviewed with NA #1. The kiosk included the intervention, "Staff to monitor me during toileting task if assisted to bathroom 	IDEPCIENCIES ORRECTION (X1) PROVIDERSUPPLERCUA IDENTIFICATION NUMBER (X2) WULTPLE CONSTRUCTION A BUILDING	

Facility ID: 923103

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED
		345015	B. WING		05	/24/2018
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•	
LAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFTING INFORMATION)	TAG	DEFICIEN		
F 600	Continued From pag	e 22	F 60	00		
:		essed Resident #28 ' s	1.00			
	•	nd noted no concerns with				
	her condition. She o					
		nents from the physician and				
	-	ssessments with no noted				
	changes in condition					
		ing and shaking early that				
	,	(18). She indicated Resident the ER for evaluation and				
	was admitted to the l					
	An interview was cor	nducted with Resident #28 on				
	5/23/18 at 9:30 AM.	She indicated she had fallen				
		facility. She stated she				
		on and off the toilet and				
		ter toileting. The 3/1/18 fall				
		ussed with Resident #28.				
		in the bathroom, the NA (NA , and she tried to get up on				
		ed she lost her balance and				
		on the bathroom floor.				
	A follow up interview	was conducted with the				
	DON on 5/24/18 at 1	0:10 AM. She stated the				
		interventions related to falls				
		sk for falls and to avoid				
	•	ne indicated she expected				
	implement them at a	are plan interventions and to				
F 637		essment After Signifcant Chg	F 63	37		6/15/18
SS=D	CFR(s): 483.20(b)(2)		1.00			
	§483.20(b)(2)(ii) Wit	hin 14 days after the facility				
		d have determined, that				
		nificant change in the				
	-	r mental condition. (For				
	purpose of this section	on, a "significant change"				
	means a major declir	and the second second the second s	1			1

Facility ID: 923103

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 07/03/20 RM APPROVE NO: 0938-039
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		TE SURVEY MPLETED
		345015	B. WING				5/24/2018
NAME OF PR	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				50	00 MOUNTAIN TOP DRIVE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC		A	SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 637	Continued From page	0.23		627			
1 057	Continued From page		F	637			
		will not normally resolve					
		ntervention by staff or by					
		rd disease-related clinical					
		s an impact on more than					
		ent's health status, and					
	care plan, or both.)	nary review or revision of the					
	• • •	Γ is not met as evidenced					
	by:	i is not met as evidenced					
	-	iew and staff interview, the			F637		
		lete a significant change in					
		a Set (MDS) assessment			This plan of correction will serve as	the	
		he resident was determined			facility's allegation of compliance with		
	-	change in health status for 1			requirements of 42 CFR, Part 483,		
	of 4 sampled residen	ts reviewed (Resident #29).			Subpart B for long term care facilitie	S.	
	Findings included:				Preparation and submission of this p	olan of	
					correction is in response to DHHS 2	567	
					for the May 21st, 2018 survey and d		
		iginally admitted to the facility			not constitute an agreement or adm		
		ple diagnoses including			of Clapp's Nursing Home of the truth		
	unspecified psychosi	S.			the facts alleged or the correctness		
	T I I · · · · · · · · · · ·				conclusions stated on the statement		
		assessment dated 3/28/18			deficiencies. This plan of correction		
		ent #29 did not have a			prepared and submitted because of	ule	
		n indwelling urinary catheter. her indicated that Resident			requirements of 42 CFR, Part 483, Subpart B throughout the time perio	Ч	
	#29 did not have beh				subpart b throughout the time peno stated in the statement of deficiencie		
					accordance with state and federal la		
	The medical records	revealed that Resident #29			however, submits this plan of correct	,	
		e hospital on 4/2/18 and was			address the statement of deficiencie		
	readmitted to the faci	•			to serve as it's allegation of complia		
		-			with the pertinent requirements as o		
	The 14 day MDS ass	essment dated 4/19/18			dates stated in the plan of correction		
		ent #29 had an unstageable			as fully completed as of 06/15/2018		
	pressure ulcer and a	n indwelling urinary catheter.					
	The assessment furth	her indicated that Resident			Key members of the QAPI committe	e met	
	#29 had displayed ve	erbal behaviors and rejection			to determine the root cause of the c	itation	
	of care.				related to F637 as well as a plan to		
					correct the citation. The Committee		

Facility ID: 923103

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TATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
	CONNECTION	DENTIFICATION NUMBER.	A. BUILDING	3	CONFLETED
		345015	B. WING		05/24/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CLAPP'S	CONVALESCENT NURS	SING HOME INC		500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLET
F 637	On 5/23/18 at 1:50 F interviewed. She rev Resident #29 and sta in status MDS should Resident #29 was re indwelling urinary ca On 5/24/18 at 9:26 A (DON) was interview expected a significar	2M, MDS Nurse #2 was viewed the medical records of ated that a significant change d have been completed when admitted. She verified that admitted with pressure ulcer, theter and with behaviors. M, the Director of Nursing red. She stated that she at change in status MDS red within 14 days after a	F 63	determined the Significant Char assessment needed for residen due to the MDS Coordinator bei insufficiently educated related to screening for significant change assessments. For the resident a significant change assessment completed by the MDS Coordin 05/25/2018. To achieve substar compliance with F637, the MDS Coordinators will audit all record residents who have discharges returned to the facility in the last to ensure no other significant ch assessments have been missed significant change assessments found, a correct assessment is completed immediately. All char reviewed by 06/15/2018. The fa coordinators were in-serviced b Director of Nursing on 06/08/20 to reviewing all new Physician C weekly at minimum in order to o clinical changes with residents v possibly warrant a significant ch assessment to be completed wi days. By pulling this report, the Coordinators will be able to recor residents who have gone out to hospital and returned with a char condition and they will also be a catch clinical changes with the r within the facility who have not I MDS Coordinators were re-edu the Director of Nursing on signif change assessment requiremer Resident Assessment Instrumer on 06/08/2018.	t #29 was ing affected, a was ator on titial ds of and t 3 months hange d. If any s are to be ts will be cility MDS y the 18 related Drders statch which may hange thin 14 MDS ognize any the ange of ible to residents eft. The cated by ficant hts per the

Event ID: 4GCC11

Facility ID: 923103

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	-	ND HUMAN SERVICES			(1 APPROVE 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345015	B. WING			05/2	24/2018
NAME OF P	ROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC			MOUNTAIN TOP DRIVE HEBORO, 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 637	Continued From page	e 25	F 6	37	To ensure substantial compliance with F637 is sustained, the Director of Nursin will audit the MDS assessments for all residents who are sent out to the hospit and return weekly for 3 months to ensur a significant change is not warranted. If substantial compliance is found during to weekly audit, the audit will then be reduced to all residents who are sent out and return to facility per month, on-going This citation and the plan of correction w be followed by the facility's QAPI Committee and results of this audit will I discussed in the bi-weekly/monthly meetings and as needed. The Director of Nursing is responsible for presenting this plan of correction to the QAPI committee Any areas of concern will be addressed upon discovery with the committee's appropriate members.	al re the g. will be of is e.	
F 641 SS=D	CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT		F 64	41			6/15/18
	facility failed to code (MDS) assessment a (Resident #28), pain infections (Resident # (Resident #56) for 3 o The findings included	iew and staff interview, the the Minimum Data Set ccurately in the areas of falls management and skin #70), and active diagnoses of 19 residents reviewed. I: admitted to the facility on			F641 This plan of correction will serve as the facility's allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan correction is in response to DHHS 2567 for the May 21st, 2018 survey and does not constitute an agreement or admission	, 5	

Event ID: 4GCC11

Facility ID: 923103

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		MEDICAID SERVICES				<u> </u>	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		E SURVEY PLETED	
		345015	B. WING		05	05/24/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE 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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 641	Continued From page	- 26	F 64	1			
		cently readmitted on 3/5/18		of Clapp's Nursing Home	of the truth of		
	with multiple diagnos			the facts alleged or the co			
		hage (bleeding in the space		conclusions stated on the			
		d the tissue covering the		deficiencies. This plan of			
	brain), subdural hem			prepared and submitted b			
	-	d its outermost covering),		requirements of 42 CFR, I	Part 483,		
	and a fall from one le	vel to another.		Subpart B throughout the			
				stated in the statement of			
		ndicated Resident #28 had a		accordance with state and			
		on 3/1/18 in which the		however, submits this plan			
	and a subdural hema	subarachnoid hemorrhage		address the statement of o			
		liona.		to serve as it's allegation of with the pertinent requiren	-		
	The quarterly Minimu	m Data Set (MDS)		dates stated in the plan of			
	· ·	12/18 indicated Resident		as fully completed as of 00			
		intact. Section J, the Health					
	•	ndicated Resident #28 had 1		Key members of the QAP	committee met		
	fall with major injury.			to determine the root caus	e of the citation		
				related to F641 as well as	a plan to		
		ndicated Resident #28 had		correct the citation. The C			
	no falls from 3/13/18	through 3/19/18.		determined the MDS coor			
	.			been sufficiently educated	· ·		
		essment dated 3/19/18		related to coding in the fal			
		28 's cognition was intact.		management, skin infectio			
	Section J, the Health	28 had 1 fall with major injury		diagnoses for 3 of 19 resid As for the three residents			
		DS assessment (3/12/18).		assessments, the MDS Co			
				submitted corrected MDS			
	An interview was con	ducted with MDS Nurse #1		on 5/23/2018. The MDS C			
	on 5/23/18 at 11:30 A	M. Section J of the MDS		re-educated related to the	previously		
		sident #28 that indicated she		listed areas and the impor			
		or injury since her previous		accurately by the Director	-		
		12/18) was reviewed with		06/06/2018. In addition, a			
	MDS Nurse #1. The			current MDS will be review	-		
		28 had no falls from 3/13/18		Consultants prior to 06/15			
	-	reviewed with MDS Nurse evealed she coded the		no other coding errors are			
		ctly for Resident #28. She		areas of falls, pain manag infections, and active diag			
		have coded the 3/19/18 MDS			rected MDS will		

Facility ID: 923103

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STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
				3	
		345015	B. WING		05/24/2018
	ROVIDER OR SUPPLIER	ING HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN TOP DRIVE 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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETI
F 641	for Resident #28 as n fall with major injury w MDS. An interview was con Nursing on 5/24/18 at she expected the MD 2a. Resident #70 was 2/4/17 and most rece with multiple diagnost failure. The quarterly Minimu assessment dated 5/7 's cognition was mod received opioid medic Section J, the Health indicated Resident #7 scheduled pain medic medications during th look back period (5/3/ A review of Resident s orders revealed the Tramadol (opioid pair (mg) 4 times daily and daily. The May 2018 included Oxycodone medication) every 8 h A review of Resident Administrator Record pain management loo MDS indicated she record	 a falls because the 3/1/18 a scaptured on the 3/12/18 ducted with the Director of t 10:10 AM. She indicated S to be coded accurately. a admitted to the facility on ntly readmitted on 3/8/17 es that included heart m Data Set (MDS) 7/18 indicated Resident #70 lerately impaired. She cation on 7 of 7 days. Conditions Section, 70 had received no cations and no PRN pain the 5-day pain management (19 - 5/7/18). #70 's May 2018 physician 'scheduled medications in medication) 50 milligrams d Tylenol 650 mg 4 times physician 's orders also HCL (opioid pain nours as needed (PRN). #70 's Medication (MAR) during the 5-day of the 5/7/18 eceived scheduled Tramadol days and PRN Oxycodone 	F 64	be completed and submitted by MDS Coordinators. To ensure substantial compliant F641 is sustained, the Director will audit ten completed assess monthly for three months to ens errors were made in the areas of pain management, skin infectio active diagnoses. If substantial compliance is found during the audit, the audit will then be redu MDS Assessments quarterly for quarters. If substantial compliar continues to be found, the audit discontinued. This citation and the correction will be followed by th QAPI Committee and results of will be discussed in the bi-week meetings and as needed. The ID Nursing will be responsible for p this plan of correction to the QA Committee. Any areas of conce addressed upon discovery with committee's appropriate member	ce with of Nursing ments sure no of falls, ns, and monthly uced to 10 three the plan of e facility's this audit u/monthly Director of presenting Pl rn will be the

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		D HUMAN SERVICES				FORM	: 07/03/2018 APPROVED
STATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE S COMPL	
		345015	B. WING		-	05/2	24/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURSI	NG HOME INC		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 ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 641	An interview was comon 5/23/18 at 11:30 A dated 5/7/18 for Reside had received no scher no PRN pain medicat back period was revie The medical record th had received schedul 5 days and PRN pain during the 5-day look MDS was reviewed w Nurse #1 revealed sh incorrectly for Reside should have indicated received scheduled p pain medications on t she made an error. An interview was com- Nursing on 5/24/18 at she expected the MD 2b. Resident #70 was 2/4/17 and most received with multiple diagnose the toe. A physician 's order of #70 indicated Doxycy milligrams (mg) twice 5/6/18) related to a fo Medication Administra indicated Resident #7 ordered. The quarterly Minimu	ducted with MDS Nurse #1 M. Section J of the MDS dent #70 that indicated she duled pain medications and ions during the 5-day look awed with MDS Nurse #1. hat indicated Resident #70 ed pain medications on 5 of medications on 3 of 5 days back period of the 5/7/18 ith MDS Nurse #1. MDS e coded the 5/7/18 MDS int #70. She reported she t that Resident #70 had ain medications and PRN he 5/7/18 MDS. She stated ducted with the Director of 10:10 AM. She indicated S to be coded accurately. admitted to the facility on ntly readmitted on 3/8/17 es that included cellulitis of dated 4/27/18 for Resident cline Hyclate (antibiotic) 100 daily for ten days (stop date ot infection. A review of the ation Record (MAR) 0 received the antibiotic as	F 641				

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/03/2018 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		345015	B. WING			05/	24/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CLAPP'S	CONVALESCENT NURS	NG HOME INC			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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 641	 's cognition was mod assessed with an acti the toe and had recei days. Section M, the indicated Resident #7 An interview was con on 5/23/18 at 11:30 A dated 5/7/18 for Resid had no foot infections Nurse #1. The medi Resident #70 had rec infection during the 5. was reviewed with MI #1 revealed she code incorrectly for Reside should have indicated foot infection on Sect Resident #70. She si An interview was con Nursing on 5/24/18 at she expected the MD 3. Resident #56 was 7/28/17. Cumulative diagnosis of diabetes insulin. A quarterly Minimum 4/24/18 indicated Res impaired in cognition. being active during th included long term (cr Medications administ assessment period in 	erately impaired. She was ve diagnosis of cellulitis of ved antibiotics on 6 of 7 Skin Conditions Section, 70 had no foot infections. ducted with MDS Nurse #1 M. Section M of the MDS dent #70 that indicated she was reviewed with MDS cal record that indicated eived antibiotics for a foot 77/18 MDS look back period DS Nurse #1. MDS Nurse ed the 5/7/18 MDS nt #70. She reported she that Resident #70 had a ion M of the 5/7/18 MDS for tated she made an error. ducted with the Director of t 10:10 AM. She indicated S to be coded accurately. admitted to the facility on diagnoses included a and long-term use of Data Set (MDS) dated sident #56 was severely Diagnoses documented as e assessment period urrent) use of insulin. ered during the seven-day dicated Resident #56 had ctions. Insulin injections and	F	641			

Facility ID: 923103

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/03/20 FORM APPROVI OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345015	B. WING		05/24/2018
NAME OF PR	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	•
CLAPP'S	CONVALESCENT NURS	ING HOME INC		MOUNTAIN TOP DRIVE	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIO
F 641	Continued From page	e 30	F 641		
F 657 SS=D	May 2018 revealed a diabetic medicine) 50 mouth twice daily. The order for insulin. On 5/23/18 at 11:20 / conducted with the lo Coordinator who stat documented on the M include only active di (current) use of insuli included on Resident On 5/24/18 at 10:15 / conducted with the D the MDS should be c diagnosis. Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Compreh §483.21(b)(2) A comp be- (i) Developed within 5 the comprehensive a (ii) Prepared by an in includes but is not lim (A) The attending phy (B) A registered nursi resident. (C) A nurse aide with resident.	MDS assessment should agnoses and the long term in should have not been t #56 's assessment. AM, an interview was birector of Nursing who stated coded accurately for d Revision (i)-(iii) ensive Care Plans prehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that nited to ysician. e with responsibility for the	F 657		6/15/18
	(E) To the extent practice the resident and the resident	d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's			

Facility ID: 923103

If continuation sheet Page 31 of 68

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	<u> </u>	· · ·	MPLETED	
		345015	B. WING			5/24/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		•	
			500 MOUNTAIN TOP DRIVE				
CLAPP'S	CONVALESCENT NURS	ING HOME INC		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 657	Continued From page	a 31	F 65	57			
		participation of the resident	1 00				
		participation of the resident					
	not practicable for the						
	resident's care plan.	· · · · · · · · · · · · · · · · · · ·					
		staff or professionals in					
		ined by the resident's needs					
	or as requested by th	e resident.					
	(iii)Reviewed and rev	ised by the interdisciplinary					
		ssment, including both the					
	comprehensive and c	quarterly review					
	assessments.						
		is not met as evidenced					
	by:			5057			
		ns, Responsible Party (RP)		F657			
		nd record review, the facility		This plan of correction will	oonyo oo tho		
		ent care plans in the areas of pain for 3 (Resident #41,		This plan of correction will facility's allegation of comp			
		sident #6) of 19 resident		requirements of 42 CFR, P			
		for revisions. The facility also		Subpart B for long term car			
		quired participants were		Preparation and submissio			
	involved in the care p			correction is in response to			
	(Resident #36) of 1 re			for the May 21st, 2018 surv			
		re planning process. The		not constitute an agreemer	•		
	findings included:			of Clapp's Nursing Home o	f the truth of		
				the facts alleged or the cor			
				conclusions stated on the s			
		admitted on 11/21/14 with		deficiencies. This plan of c			
		s of a left above the knee		prepared and submitted be			
		eripheral Artery Disease		requirements of 42 CFR, P			
	(PAD) and Adult Failu			Subpart B throughout the ti	-		
				stated in the statement of c accordance with state and			
	The quarterly Minimu	m Data Set (MDS) dated		however, submits this plan			
		ere cognitive impairment, no		address the statement of d			
		taff assistance for all her		to serve as it's allegation of			
		g (ADLs). Resident #41 was		with the pertinent requirem			
	coded for 2 unstagea			dates stated in the plan of			
		· · · · · · · · · · · · · · · · · · ·				1	

Event ID: 4GCC11

Facility ID: 923103

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		MEDICAID SERVICES				<u>10. 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		345015	B. WING		0	5/24/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
CLAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 657	Continued From pag	e 32	F 65	57		
		potential for pressure ulcers		Key members of the QA	PI committee met	
		ondition. She was care		to determine the root car		
		sure ulcer to her right foot.		related to F657 as well a		
		-		correct the citation. The	committee	
		#41's electronic and written		determined there was ar		
		ated she developed an		MDS Coordinator when	-	
		e ulcer to her sacrum and a ue injury to her left buttock on		plans for 3 of 19 residen education needed to be		
		an and her RP were notified		committee also determin	•	
	-	en to treat both new areas.		employees had misinter	•	
				Aide's role in the care pl		
	Observation of the rig	ght foot, left buttock and		per the new care plannin		
	-		achieve substantial com	-		
		#2 stated the area to her		all individuals responsibl	÷ .	
		um were newly developed. ved concerns with the		the care planning proces on the new care planning		
		ime or technique. Resident		the Director of Nursing of		
		ire reducing mattress and a		The individuals responsi		
	cushion was observe	0		planning process include Manager, MDS Coordina	e the Dietary	
	Interview with Reside	ent #41's RP was conducted		Worker and Activities Ma	anager. All care	
		PM. She stated that Resident		plan committee member		
		her remaining foot but the		on exactly which staff me		
		s and sacrum were new. She		required to be a part of t		
		s treating her pressure ulcers ements to aid in healing but		process, specifically rela Aide's role in the care pla		
		as continuing to gradually		The care plans of reside		
	decline.			#6, were also updated b		
				Coordinators to accurate	ely reflect the	
		Nurse #1 was conducted on		resident's care needs sp	•	
		. She stated the actual		to pressure ulcers and p		
	· ·	esident #41's left buttock and		Consultants will audit all	-	
		been care plan when they 8. She stated she only		current residents by 06/1 all care plans accurately		
	-	e new area this week. She		ulcers or pain if applicab	-	
	stated it was an over			coordinators were also e		
		-		Director of Nursing on 00		
		on 5/24/18 at 10:17 AM, the		to timely updating the re-		
	Administrator and DC	ON both indicated it was their		to accurately reflect the	care needs of the	

Facility ID: 923103

If continuation sheet Page 33 of 68

					OMB NO. 0938-0
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345015	B. WING	<u></u>	05/24/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE
CLAPP'S	CONVALESCENT NURS	ING HOME INC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLET D THE APPROPRIATE DATE
F 657	Continued From page	e 33	F 65	57	
	have been revised or development of the p #41's sacrum and left 2. Resident #74 was cumulative diagnoses pneumonia and deme Review of Resident # 2/24/18 did not includ except for a standing	admitted on 2/24/18 with s of acute respiratory failure, entia. 474's admission orders dated de any medications for pain order for Tylenol 650		resident specifically relate pressure ulcers. They we specific information relate appropriate time to care p for pain or pressure ulcer pain or pressure ulcer. In order to ensure on-goi with F657, the DON or U participate in 5 care plan month for three months to required employees activ	ere provided ed to the blan "potential" versus "actual" ng compliance nit managers will meetings per b ensure all rely participates
	indicated a new order medication used to tr every night and scher 6 hours were started	74's written physician orders r for Neurontin (anti-epileptic eat nerve pain) 100 mg duled Tylenol 650 mg every on 3/2/18 for pain.		in the care plan meeting a substantial compliance is care plan meetings for th months, the audit will be care plan meetings per q quarters. If substantial co continues to be found, th discontinued. Also to ens	found during the e first three reduced to 5 uarter for three ompliance e audit will be ure on-going
	for pain on 3/2/18. Th prescribed Neurontin Resident #74's admis	ssion Minimum Data Set		compliance with F657, th Nursing will audit 20 care for 3 months to verify the accurately reflects the ca resident related to pressu	e plans per month care plan re needs of the ure ulcer and
	impairments with no l	ndicated moderate cognitive behaviors. She was coded d pain and ordered pain d.		pain. If substantial compl during these monthly auc then be reduced to 20 ca quarter for three quarters compliance continues to	lits, the audit will re plans per 5. If substantial
	she was prescribed C pain-reliever) 5 mg ev	very 4 hours as needed for in was increased to 300 mg		audit will be discontinued and the plan of correction in the facility's QAPI Com results of this audit will be the bi-weekly/monthly me needed. The Director of I	n will be followed nmittee and e discussed in eetings and as
		n progress note dated sident #74's chronic joint		responsible for presenting correction to the QAPI co areas of concern will be a	g this plan of ommittee. Any

Facility ID: 923103

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/03/2018 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION	(X3) DATE	
		345015	B. WING			05/	24/2018
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CLAPP'S	CONVALESCENT NURSI	NG HOME INC			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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	she was prescribed T used to treat pain) 50 needed for pain on 4/ Interview was conduct private sitter on 5/21/ Resident #74's suffer a fall with injury some sitter and Resident #7 under control with the since her admission. Interview with the MD on 5/23/18 at 11:40 A should have been car care plan should have new orders for the Ox She stated it was an or During an interview of Administrator and Dir indicated it was their #74's care plan would 3/23/18 for actual pain stated the care plan s revised on 4/26/18 wh ordered for pain. 3. Resident #6 was of facility on 6/12/07 with including Multiple Scle Minimum Data Set (M	74's written orders indicated ramadol (a synthetic opioid mg every 6 hours as 26/18. ted with Resident #74's 18 at 3:21 PM. She stated ed from chronic pain due to years ago. The private '4 reported her pain was new medications ordered S Nurse #1 was conducted M. She stated actual pain e planned on 3/2/18 and her e been revised to include the sycodone and Tramadol. oversight. n 5/24/18 at 10:17 AM, the ector of Nursing both expectation that Resident I have been revised on n and the Oxycodone. Both hould have again been nen the Tramadol was	F	657	DEFICIENCY) discovery with the committee's appropriate members.		
	The weekly wound as	sessment revealed that					

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/03/2018 APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345015	B. WING			05/	24/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S			
CLAPP'S	CONVALESCENT NURSI	NG HOME INC		500 MOUNTAIN TOP DRIV ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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)		(X5) COMPLETION DATE
F 657	her sacrum on 3/23/14 Resident #6's care pla plan dated 2/21/18 ind was at risk for skin bry the goal was for her s redness or open area and goal were not rev pressure ulcer. On 5/23/18 at 11:40 A interviewed. She veri pressure ulcer on her had failed to revise th actual open area/press On 5/24/18 at 9:26 AN (DON) was interviewe expected the care pla resident developed a 4. Resident #36 was a 4/22/17 and most reco with multiple diagnose hemiplegia (paralysis affecting the right dom Mellitus. The quarter assessment dated 4/2 s cognition was mode A review of the medic Assistant (NA) assign was not included in th care plan review/revis 1-year period.	eloped a pressure ulcer on 8. an was reviewed. The care dicated that Resident #6 eakdown/pressure ulcer and kin to remain intact with no s. The care plan problem ised to address the actual M, MDS Nurse #1 was fied that Resident #6 had a sacrum and stated that she e care plan to address the sure ulcer. A, the Director of Nursing ed. She stated that she n to be revised when a pressure ulcer. admitted to the facility on ently readmitted on 6/27/17 es that included dementia, of one side of the body) ninant side, and Diabetes y Minimum Data Set (MDS) 2/18 indicated Resident #36' rately impaired. al record revealed a Nursing ed to care for Resident #36 e care plan meetings or the ion process for over a	F 657				
	- The care plan signal	ture pages dated 5/2/17, 17, 1/2/18, 4/2/18, and					

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CENTER STATEMENT (-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		FORM OMB NO (X3) DATE	0: 07/03/2018 1 APPROVED 0: 0938-0391 SURVEY LETED
		345015	B. WING		_	05/2	24/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURSI	NG HOME INC		00 MOUNTAIN TOP DRIVI 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 BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	dated 8/16/17, 9/20/1 2/21/18, 4/18/18, and was not present at the An interview was com- on 5/23/18 at 11:50 A that care plan meeting and review the care plan coordination with each of the MDS Nurses, d and the SW. She rep the care plan signed to page to indicate the c MDS Nurse #1 reveal facility practice for an to attend the care plan NAs had busy schedu attending the meeting revealed it was not no NA assigned to the re- care plan review/revis signing the signature This interview with MI She stated she was th Resident #36. She co- present at any of the past year nor had an care plan for Residen An interview was com- on 5/23/18 at 2:00 PM meetings were utilized care plans were also	NA signatures. ng notes for Resident #36 7, 10/18/17, 12/20/17, 5/16/18 all indicated an NA e meetings. ducted with MDS Nurse #1 M. MDS Nurse #1 stated gs were utilized to develop lans for all residents. She ans were also reviewed in h MDS assessment by one lietary staff, activities staff, borted the staff that reviewed their name on the signature are plan had been reviewed. led that it was not normal NA assigned to the resident n meetings. She stated the ules which would have made us difficult. She additionally ormal facility practice for an esident to be included in the sion process which included page of the care plans. DS Nurse #1 continued. he MDS Nurse assigned to onfirmed an NA was not care plans meeting over the NA reviewed and signed the	F 657				

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DA	TE SURVEY
ND PLAN OI	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		со	MPLETED
		345015	B. WING		0	5/24/2018
NAME OF P	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURS	SING HOME INC) MOUNTAIN TOP DRIVE SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 657 F 687 SS=D	She reported the star signed their name or indicate the care plan confirmed MDS Nurs not normal facility pra- care plan meetings. NAs reviewed the ba- plan, but were not im- process of subseque An interview was cor Administrator and Di 5/24/18 at 10:10 AM known if the regulation to be included in the indicated their expect to be followed. The Di assigned to the reside familiar with them an aware of the care plan Foot Care CFR(s): 483.25(b)(2) §483.25(b)(2) Foot cor To ensure that reside and care to maintain health, the facility main (i) Provide foot care as with professional star to prevent complication medical condition(s) (ii) If necessary, assi- appointments with a	activities staff, and the SW. ff that reviewed the care plan in the signature page to in had been reviewed. She se #1 's statement that it was actice for an NA to attend the MDS Nurse #2 stated that iseline/initial admission care cluded in the review/revision ent care plans. Inducted with the rector of Nursing (DON) on . Both reported they had not ons required a direct care NA care planning process. They station was for the regulations DON added that the NAs lents were usually the most id therefore they should be an.)(i)(ii) are. ents receive proper treatment mobility and good foot ust: and treatment, in accordance ndards of practice, including ions from the resident's	F 657			6/15/18

Event ID: 4GCC11

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		345015	B. WING		05/24/2018	
AME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC	500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	RECTION (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLET	
F 687	Continued From page	e 38	F 68	7		
	Based on observation	on, responsible party, staff		F687		
		d review, the facility failed to		This plan of correction will serve	e as the	
	provided foot care as	ordered for 1 (Resident		facility's allegation of complianc		
		eviewed for foot care. The		requirements of 42 CFR, Part 4		
	findings included:			Subpart B for long term care fac		
				Preparation and submission of	•	
		dmitted on 11/21/14 with		correction is in response to DH		
		s of a left above the knee		for the May 21st, 2018 survey a		
	(PAD) and Adult Failu	eripheral Artery Disease		not constitute an agreement or of Clapp's Nursing Home of the		
				the facts alleged or the correctn		
				conclusions stated on the state		
	Review of a Podiatrv	Assessment and Doctor's		deficiencies. This plan of correct		
	-	20/17 indicated Resident #41		prepared and submitted becaus		
	required podiatry ser	vices due a history of a		requirements of 42 CFR, Part 4	83,	
		tion, thick toenails and		Subpart B throughout the time p		
		s (thickening of the outer		stated in the statement of defici		
	layer of the skin). The			accordance with state and fede		
	Resident #41 attendi	ng physician.		however, submits this plan of co		
				address the statement of deficie		
	Peview of a podiatry	note dated 10/24/17 read as		to serve as it's allegation of com with the pertinent requirements	-	
		le knee amputation. Toenails		dates stated in the plan of corre		
		d of reduction. The right		as fully completed as of 06/15/2		
	u u u u u u u u u u u u u u u u u u u	rown. Hyperkeratotic lesion		Key members of the QAPI com		
	• •	n ulcer therefore, it was		to determine the root cause of t		
		essional foot care was		related to F687 as well as a pla		
		d Resident #41 was to be		correct the citation. The usual p		
	seen in three months	or sooner if necessary.		assembling the list of residents		
		· · · · · ·		to be seen during the upcoming	-	
		of residents to be seen on		visit is for the podiatry company		
	2/26/18 did not includ			the notes from the previous visi create a list of residents who ne		
				seen again during the next visit		
	The quarterly Minimu	ım Data Set (MDS) dated		the podiatrist's notes. This list is		
		vere cognitive impairment, no		the Resident Coordinator at the		
		taff assistance for all her		who then adds any newly referr	2	
	activities of daily livin			residents to be seen. Once it wa		
	, , , , , , , , , , , , , , , , , , , ,	- · · /		discovered that Resident #41 ha		

Facility ID: 923103

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		NO. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	OMPLETED	
		345015	B. WING			05/24/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD			
CLAPP'S	CONVALESCENT NURS	ING HOME INC	500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203				
		ATEMENT OF DEFICIENCIES	I	PROVIDER'S PLAN OF CO	PRECTION	(XE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 687	Continued From page	e 39	F 68	7			
	Resident #41's care	olan last revised on 4/11/18		left off the list to be seen durin	ig the		
		al staff assistance for her		February 2018 visit, the Podia	-		
		as care planned for one		was called and the resident w	• • •		
	pressure ulcer to her	right foot.		5/30/2018. In order to ensure			
				residents within the facility are			
		ent #41 on 5/21/18 at 2:35		need of a podiatry visit, all res			
		her wheelchair in the hall.		were assessed by a nurse wit			
		ght foot were noted long and		facility by 06/13/2018. No resi			
	thick.	scolored and appeared to be		found to be in need of a podia resident in need of being seer			
	UIICK.			referral made and an appointr			
	During a wound care	observation on 5/22 at 11:42		scheduled for the first available			
	-	the podiatrist provided foot		order to ensure compliance w			
		I. She stated, "Doesn't		facility has initiated a new pro-			
		in a while". Nurse #2 stated		which the Staff Coordinator or			
	the Staffing Coordina	tor was responsible for		Manager will go through all po	diatry notes		
	setting up podiatry vis	sits.		after their visit and assemble	the list of		
				residents who need to be see			
		at 12:00 PM, Resident #41's		next visit. This list is to be con	•		
		P) stated Resident #41's		the list which the contract pod	-		
		ed by the facility podiatrist.		company sends as well. This			
	seen. She stated it had bee	en a while since she was		change will prevent residents omitted in the future. The Stat	-		
	upcoming podiatry vis	•		Coordinator was educated on			
		5115.		protocol by the Director of Nu			
	Observation on 5/23/	18 at 8:20 AM, Resident #41		06/08/2018.	enig en		
		with Nursing Assistant (NA)					
		fast. Resident #41's right		To ensure continued compliar	ice with		
		d as described on 5/21/18.		F687, the DON or Unit Manag			
		es were not allowed to trim		the podiatry notes and the list			
		ted she thought Resident		by the Staff Coordinator for th			
	#41 was being follow	ed by the podiatrist.		scheduled quarterly podiatry v			
	Intonvious on E/22/42	at 9:29 AM the Staffing		list is accurate and complete a			
		at 8:38 AM, the Staffing		scheduled podiatry visits, the			
		ne was responsible for ents who needed to be seen		then be reduced to once per y year. If substantial compliance			
		e podiatrist. She stated		to be found, the audit will then			
		t on the list to be seen on		discontinued. This audit will en			
		Coordinator was unable to		solutions put in place by the fa			

Facility ID: 923103

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345015	B. WING		05/24/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURS	NG HOME INC	500 MOUNTAIN TOP DRIVE 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC	
not seen by the podiatrist Telephone interview on 5		as to why Resident #41 was ttrist on 2/26/18. on 5/24/18 at 9:18 AM, the	F 687	successful and sustained. In additi hall nurses will continue to observe resident's feet during their weekly checks on all residents and make referrals as needed. This citation a	e skin podiatry	
	Nurse Practitioner stated it was her expectation that all orders and treatments be done. She stated if Resident #41 was sick at the time the podiatrist visited the facility in February, it could account for the delay in foot care. Review of Resident #41's electronic and written medical record indicated she was treated for pneumonia			plan of correction will be followed I facility's QAPI Committee and resu this audit will be discussed in the bi-weekly/monthly meetings and a needed. The Director of Nursing is responsible for presenting this plan	by the ults of s n of	
	used to treat and pre- through 1/31/18. Res the time of the podiat reviewed with the NP	Tamiflu (antiviral medication vent influenza from 1/22/18 sident #41's health status at rist visit on 2/26/18 was . She stated it would be her dent #41's toenails would		correction to the QAPI Committee. areas of concern will be addressed corrected upon discovery with the committee's appropriate members	d and	
	when she documenter completed in the elect was only ensuring he She stated she did no toenails due to her his diagnoses of PAD. No	at 9:25 AM, Nurse #1 stated ed the nail care as being tronic medical record, she r fingernails were trimmed. ot trim Resident #41's story of a left AKA and urse #1 stated Resident #41 of the podiatrist for her foot				
	Nurse #3 stated she nail care in the electro looked at Resident #4 stated she could not	on 5/24/18 at 9:44 AM, documented Resident #41's onic record and thought she 11's toenails last week. She recall what they looked like y needed to be trimmed, she a unless it was				

If continuation sheet Page 41 of 68

		ND HUMAN SERVICES			PRINTED: 07/03/20 FORM APPROVI
STATEMENT C	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		345015	B. WING		05/24/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • • • • • • • • • • • • • • • •
	CONVALESCENT NURS			500 MOUNTAIN TOP DRIVE	
CLAFF 5	CONVALESCENT NORS			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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLETIO
F 687	Continued From page	e 41	F 68	.7	
	Interview on 5/24/18 Administrator and Dir was their expectation as order for Resident	at 10:17 AM, the rector of Nursing stated it that foot care be provided #41 and be done by a due to her diagnosis of PAD			
F 688 SS=D	Increase/Prevent Dec	crease in ROM/Mobility	F 68	8	6/15/18
	resident who enters t range of motion does range of motion unles	cility must ensure that a he facility without limited a not experience reduction in ss the resident's clinical es that a reduction in range able; and			
	motion receives appr services to increase r	ent with limited range of opriate treatment and range of motion and/or to ase in range of motion.			
	receives appropriate assistance to maintai the maximum practic reduction in mobility i	ent with limited mobility services, equipment, and n or improve mobility with able independence unless a s demonstrably unavoidable.			
	by: Based on observatio	Is not met as evidenced In, Responsible Party (RP) Ind record review, the		F688 This plan of correction will serve as	the
	facility's staff failed to a resident's right cont order to prevent wors	p place a rolled wash cloth in tracted hands per physician sening of the contracture for resident reviewed for range		facility's allegation of compliance w requirements of 42 CFR, Part 483, Subpart B for long term care facilitie Preparation and submission of this correction is in response to DHHS 2	ith es. plan of 2567
	included:			for the May 21st, 2018 survey and on not constitute an agreement or adm	

Event ID: 4GCC11

Facility ID: 923103

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		MEDICAID SERVICES				0.0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED
		345015	B. WING		05/	24/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE	
CLAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 688	Continued From page		F 68			
	Resident #24 was admitted to the facility on 2/23/94 with cumulative diagnoses of nontraumatic subdural hematoma and contractures.			of Clapp's Nursing Hom the facts alleged or the conclusions stated on th deficiencies. This plan prepared and submitted	correctness of the ne statement of of correction is	
	(MDS) dated 3/14/18 moderate cognitive ir and needed total staf activities of daily livin	erly Minimum Data Set indicated the resident had npairment, had no behaviors ff assistance for all her g (ADLs). She was coded		requirements of 42 CFF Subpart B throughout th stated in the statement accordance with state a however, submits this p	ne time period of deficiencies. In Ind federal law,	
	her upper body. Resident #24's last re	impairment on one side of evised care plan dated		address the statement of to serve as it's allegatio with the pertinent requir dates stated in the plan	n of compliance rements as of the of correction and	
		e was to have right hand ily, and a rolled wash cloth		as fully completed as of Key members of the QA to determine the root ca related to F688 as well	API committee met ause of the citation	
	2018 orders read an her right hand daily w	#24's current electronic May order dated 9/25/17 to clean vith soap and water, dry e a rolled wash cloth in her		correct the citation. Upo was discovered the orde management were not the way so that the CNA's c	ers for contracture being entered in a	
	right hand.	∉24's May 2018 Treatment		contraction prevention in each resident. To achier F688, the MDS Coordin	nstructions for ve compliance with	
	Administration Recor initialed daily at 7:15 #24's right hand was	d (TAR) revealed the nurses AM indicating that Resident washed with soap and		in-serviced on 06/08/20 of Nursing related to en contracture prevention i	18 by the Director tering the instructions into	
		nly then a rolled wash cloth ht hand. The TAR indicated dered 9/25/17.		the care plan so the CN instructions and check of completed the tasks on All CNA's will also be in	off on having the CNA's kiosks.	
	Guide read as follows hand. Make sure the	ed electronic Daily Care s: I have a contracted right right hand was washed and ed wash cloth in the right		Director of Nursing by 0 to view these contractio instructions and the imp contraction prevention r	n prevention portance of	
	hand.	lent #24 on 5/21/18 at 2:19		followed. On of before C MDS Coordinators and Nursing audited all char	06/15/2018, the Director of	

Facility ID: 923103

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G		MPLETED
		345015	B. WING		0	5/24/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
CLAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 688	Continued From page	e 43	F 68	8		
	1.0	She was sitting up in a		with contracture preventior	n protocols in	
	wheelchair in her roo	•		place to ensure the preven		
		e. There was no observed		entered in to the task care		
	rolled up wash cloth i			viewable by the CNA on al		
				residents had their contrac	•	
		18 at 4:45 PM revealed no		protocols in place as order		
	rolled wash cloth to F	Resident #24's right hand.		areas of concern were four	nd.	
	Observation on 5/22/	18 at 9:31 AM revealed no		To ensure this process is w	vorking	
	rolled wash cloth to F	Resident #24's right hand.		appropriately, the Unit Mar		
				Coordinator will observe 5	residents a	
		18 at 11:32 AM revealed no		week with contracture man	-	
	rolled wash cloth to F	Resident #24's right hand.		protocols in place to ensur are being followed. The Dir		
	Observation on 5/22/	18 at 2:30 PM revealed no		Nursing will visit the reside	nts at a time	
	rolled wash cloth to F	Resident #24's right hand.		when the contracture mana		
				protocol is to be in place. T		
		18 at 4:20 PM revealed no		Nursing will perform her ob		
	rolled wash cloth to F	Resident #24's right hand.		all shifts and on weekends		
	Observation on 5/23/	18 at 8:25 AM revealed no		compliance is found during observations, the audit will	•	
		Resident #24's right hand.		reduced to 5 residents per		
				months. If substantial com		
	Observation on 5/23/	18 at 10:15 AM revealed no		found, the audit will then be		
	rolled wash cloth to F	Resident #24's right hand.		residents per quarter, on-g on-going audit will ensure	oing. This	
	Observation on 5/23/	18 at 10:51 AM revealed no		solutions are sustained. Th		
		Resident #24' right hand. At		the plan of correction will b		
		vation, an interview was		the facility's QAPI Committ		
		ng Assistant (NA) #4. She		of this audit will be discuss		
		aced a rolled wash cloth in		bi-weekly/monthly meeting		
		hand but she forgot to do it		needed. The Director of Nu	-	
		a wash cloth to Resident		responsible for presenting		
	-	out difficulty and Resident		correction to the QAPI corr		
	#24 made no attempt			areas of concern will be ad		
	During an interview o	n 5/23/18 at 12:12 PM,		discovery with the committ appropriate members.	CC 3	
		signed off on the TAR that				
		wash cloth was in her right				

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		ID HUMAN SERVICES				FORM	0: 07/03/2018
STATEMENT (S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	-	(X3) DATE COMP	
		345015	B. WING		_	05/2	24/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURSI	NG HOME INC		500 MOUNTAIN TOP DRIV 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 688	#24 removed the was reviewed with Nurse # Resident #24 refused and contracture mana indicated Resident #2 cloth in her right hand During an interview of #5 stated she only cle hand daily. She stated anything ordered for H was closed too tight. I what was indicated or computer to know who planned for Resident During an interview of and NA #6 stated they in the computer to know utilized for each resid stated she had never a rolled wash cloth to she ensured Resident but never placed a rol hand. During an interview of and worsening of her Resident #24 was not cloth from her right had Observation on 5/23/2	he stated maybe Resident sh cloth. Care plan was #1. The care plan indicated restorative range of motion agement. The care plan 24 was to have a rolled wash 5. n 5/23/18 at 12:05 PM, NA eaned Resident #24's right d Resident #24 did not have her right hand because it NA #5 stated she followed in the Daily Care Guide in the at interventions were care #24. n 5/23/18 at 4:02 PM, NA #3 y used the Daily Care Guide ow what interventions were ent they cared for. NA #3 observed Resident #24 with her right hand. NA #6 stated t #24's right hand was clean lled wash cloth in her right n 5/23/18 at 2:00 PM, MDS was aware that Resident wed splinting for her right nave a rolled wash cloth to rent possible skin breakdown contracture. She stated t known to remove the wash	F 68	В			

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	: 07/03/20 APPROVE . 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE S COMPL	
		345015	B. WING		05/2	24/2018
	ROVIDER OR SUPPLIER	ING HOME INC		TREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ASHEBORO, NC 27203 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 688	Continued From page	e 45	F 688			
		18 at 4:00 PM revealed rolled wash cloth to her right				
		18 at 8:20 AM revealed rolled wash cloth to her right				
	PM, Resident #24's F right-hand contractur	nterview on 5/21/18 at 4:14 RP stated the resident had a e and that the staff were cloth in daily to prevent skin ht hand.				
	Administrator and Dir it was their expectation	on 5/24/18 at 10:17 AM, the rector of Nursing both stated on that the staff ensure rolled wash cloth in her right d by the physician.				
F 689 SS=G	Free of Accident Haz CFR(s): 483.25(d)(1)	ards/Supervision/Devices (2)	F 689			6/15/18
	supervision and assist accidents.	esident receives adequate stance devices to prevent Γ is not met as evidenced				
	Based on record rev staff interview, the fa- resident who required 1 staff for toileting fro	iew, resident interview, and cility failed to prevent a d the extensive assistance of m falling in the bathroom arachnoid hemorrhage		F689 This plan of correction will serve as facility's allegation of compliance wit requirements of 42 CFR, Part 483, Subpart B for long term care facilitie	th	

Event ID: 4GCC11

Facility ID: 923103

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	· · · ·	E SURVEY IPLETED
		345015	B. WING		0	5/24/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
CLAPP'S	CONVALESCENT NURS	ING HOME INC	500 MOUNTAIN TOP DRIVE 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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	 689 Continued From page 46 (bleeding in the space between the brain and the tissue covering the brain) and a subdural hematoma (pool of blood between the brain and its outermost covering). Resident #28 was assisted to the bathroom by Nursing Assistant (NA) #1, NA #1 exited the bathroom to retrieve items from the resident 's room, and Resident #28 fell as she attempted to transfer independently from the toilet to her wheelchair while unattended by staff. This was for 1 of 5 residents reviewed for accidents. The findings included: Resident #28 was admitted to the facility on 11/21/17 and readmitted on 1/5/18 with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), adult failure to thrive, age related debility, weakness, and difficulty in walking. The admission Minimum Data Set (MDS) 		F 6	Preparation and submiss correction is in response for the May 21, 2018 sur constitute an agreement Clapp's Nursing Center of facts alleged or the correc conclusions stated on the deficiencies. This plan of prepared and submitted requirements of 42 CFR Subpart B throughout the stated in the statement of accordance with state ar however, submits this pl address the statement of to serve as it's allegation with the pertinent required dates stated in the plan of as fully completed as of Key members of the QA to determine the root car	e to DHHS 2567 rvey and does not of the truth of the ectness of the e statement of of correction is because of the , Part 483, e time period of deficiencies. In and federal law, an of correction to f deficiencies and of compliance ements as of the of correction and 06/15/2018. PI committee met use of the citation	
	#28 's cognition was behaviors and no reje required the extensiv staff with bed mobility assistance of 1 staff 1 personal hygiene. SI assistance of 1 staff 1 was not steady on he stabilize without staff wheelchair and walke with her range of mot frequently incontinent The Care Area Asses Activities of Daily Livi	12/18 indicated Resident fully intact. She had no ection of care. Resident #28 e assistance of 2 or more y and the extensive for toileting, dressing, and he required the limited for transfers. Resident #28 er feet, but she was able to assistance. She utilized a er and had no impairment tion. Resident #28 was t of bladder and bowel. essment (CAA) related to ng (ADLs) for Resident #28 ' ated she required limited to		related to F689. The con determined the care plan inaccurately addressed to needs at the time of the committee also determin such as fall interventions are responsible for were in the care plan in such a CNAs were able to see to kiosks. To minimize risk having further accidents was updated correctly so tasks and responsibilities interventions, would sho care plan for the CNA's to to view this information a to know specifically the a	n for Resident #28 the resident's fall. The ned that tasks, s, which the CNAs not being layered a way that the the tasks on their of Resident #28 , the care plan o that the CNA's s, including fall w up in the task to see. Being able allows the CNA's	

Facility ID: 923103

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	S FOR MEDICARE &				OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345015	B. WING		05/24/2018
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·
			50	00 MOUNTAIN TOP DRIVE	
CLAPP'S	CONVALESCENT NURS		A	SHEBORO, NC 27203	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC
F 689	Continued From pag	e 47	F 689		
	to a debilitated state, problems. The CAA #28 ' s 1/12/18 MDS falls with injury. Resident #28 ' s plar area of the potential initiated on 11/28/17 The interventions incomonitor me during to bathroomtransfer leave me alone in ba A review was conduct for Resident #28 ' s to through 3/1/18. The Resident #28 ' s leve toileting varied from staff to total depended An incident report da Nurse #1 indicated F unwitnessed fall with Resident #28 ' s injur - superficial, bruise/r	cted of the NA documentation colleting task from 2/1/18 NA documentation indicated of required assistance for the limited assistance of 1 ence of 2 or more staff.		resident needs during toileting task Specific interventions which have I implemented since resident's first i 03/01/2018 and to minimize risk of include: Resident given non-skid s and educated on the importance o wearing them and education provid not attempted to transfer from any without assistance. The Task Care plan was updated o 05/23/2018 to reflect all appropriat interventions for Resident #28. All charts of residents with fall intervent in place were audited by the MDS Consultants prior to 06/15/2018 to the interventions which CNAs were responsible for were both accurate viewable by the CNA. Also prior to 06/15/2018, the Director of Nursing MDS Coordinator completed a full all physical fall interventions and v the physical interventions were in p The facility has now initiated a new process for entering CNA tasks int care plan in order for the CNA to b to see their required tasks/duties. A nurses and CNAs will be re-educa	been fall on falls ocks f ded on surface on e fall current ntions ensure e and g and audit of erified olace. v o the e able All
	the floor as she was her wheelchair. Res two skin tears, one to the left knee. Both s dressed. An ice pac #28 ' s head. She w wheelchair by 2 staff Responsible Party (F			where to view the task care plan b 06/15/2018 by DON or Unit Manag They were also educated that interventions in which CNAs are responsible for will be viewable on task care plan so the CNA can view care planned interventions every s The facility has created a QAPI au monitoring the fall interventions list the resident's care plan, task care and are being followed as written.	the w the hift. dit for ted on plan,

STATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345015	B. WING		05/24/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·	
CLAPP'S	CONVALESCENT NURS	NG HOME INC		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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET	
F 689	Continued From page	e 48	F 68	9		
	indicated NA #1 was following Resident #2 Resident #28 was fou bathroom after attem Resident #28 was as prior to the fall. She s transfer to her wheeld provided a written sta indicated Resident #2 3/1/18 around 7:50 A light and proceeded ther bathing and dress Resident #28 to her b Resident #28 to her b Resident #28 to her b Resident #28 is bedr after she had transfer wheelchair to the toile bathroom to pick-up t and linens from the file indicated while she w she heard Resident # Resident #28 had not assistance and she h #1 indicated she remit the call light for assist A nursing note dated #1 confirmed the info dated 3/1/18. The no Resident #28 had but and neurological assessor A review was conduct assessments dated 3	the first staff present :8 ' s unwitnessed fall. ınd on the floor in her		compliance on-going, 5 Care P audited per week x 4 weeks by Director of Nursing to ensure p interventions are listed on the r care plan, task care plan, and a physical interventions are in pla substantial compliance is found will be reduced to 2 Care Plans x 3 months. Once the audits ar the QAPI committee will review and determine the frequency o going forward. Also to ensure of compliance, the unit managers of nursing will observe 5 CNA's for 4 weeks during one toileting ensure care planned interventio being followed by CNA. If subs compliance is found during the audit, the audit will then be red CNAs monthly for 3 months. Th will be completed on all shifts a on weekends. If substantial cor continues to be found during the audit, spot checks will continue managers on an on-going basis QAPI committee will discuss th and results of this Plan of Corre the bi-weekly/monthly meetings often if needed. The Director of will be responsible for presentii of correction to the QAPI comm areas of concern will be address accordingly by the appropriate members.	w the verified of the audit service of the audit service of the audit service of the audits of the a	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345015	B. WING			05/	24/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CLAPP'S	CONVALESCENT NURS	NG HOME INC			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page A nursing note dated indicated Nurse #1 w room. Resident #28 shaking. She stated t feel good. The phys order was received to Emergency Room (El The ER records indic in the Emergency De neurology consultatio presented with a trau Hemorrhage (SAH) o (computerized tomog suspected Subdural H admitted to the hospir and monitoring. This was discussed wheth appropriate on neurol service, but medicine comfortable managin s bleed. The hospital #28 remained in the h	a 49 3/1/18 at 12:02 PM as called to Resident #28 ' s had vomited and was her head hurt and she didn ' sician was notified and an o send Resident #28 to the R) for evaluation. ated Resident #28 was seen partment on 3/1/18 and a in was ordered. The in indicated Resident #28 matic Subarachnoid in the right side. A head CT raphy) scan showed Hematoma (SDH). She was tal for repeat CT head scans consultation noted that it er Resident #28 was more logy service or medicine	F	889			
	updated on 3/5/18 wit intervention, "Do not	leave Resident alone in a duplicate intervention as it					
	indicated Resident #2 facility following a hos in closed head trauma	ess note dated 3/28/18 28 was readmitted to the spital stay for a fall resulting a, SAH, and SDH. at the hospital showed					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/03/2018 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	
		345015	B. WING			05/	24/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	500 MOUNTAIN TOP DRIVE		
CLAPP'S	CONVALESCENT NURSI	NG HOME INC		A	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From page stability.	9 50	F	689			
		al record indicated Resident er baseline health status.					
	#28 was reviewed on for Resident #28 inclu monitor me during toi	leting task if assisted to ack to chair/bed. Do not					
	5/22/18 at 3:05 PM. interventions on the or NA Daily Care Guide the intervention was i then it was also in pla Guide. The interventi indicated, "Staff to mo task if assisted to bat chair/bed. Do not lea was reviewed with the intervention was in pla	ducted with the DON on The DON stated that the are plan were linked to the interventions. She stated if n place on the care plan, ice on the NA Daily Care ion for Resident #28 that onitor me during toileting hroomtransfer back to ve me alone in bathroom" e DON. She confirmed this ace on the care plan and on ide at the time of Resident					
	at the facility for about familiar with Resident Resident #28 was a fa falls. She confirmed Resident #28 on 3/1/ AM fall. She stated s to the bathroom after bathing. NA #1 indica Resident #28 to the to	She stated she had worked t 3 years and she was #28. She reported all risk and she had several she was working with 18 at the time of her 8:15 he had taken Resident #28 she assisted her with					

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						0.0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY PLETED	
		345015	B. WING		05/	24/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CLAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIOI DATE	
F 689	changed Resident #2 prior to transferring R and back to her whee to retrieve a roll of tra Resident #28 ' s room out of the bathroom f she heard Resident # the bathroom, and sh #1 confirmed that Re attempting to self-tran This interview with N asked how she was r interventions that we NA kiosk, an electron Care Guide, had a lis for each resident. T #28 was reviewed wi included the interven during toileting task if transfer back to cha alone in bathroom." had assisted Resider left her alone while sl resident ' s room. She known this interventiof #28. She reported th was able to toilet inde needed assistance cl An interview was con 5/23/18 at 9:06 AM. at the facility for over familiar with Residen Resident #28 was a f falls. She confirmed Resident #28 on 3/1/	28 's brief. She reported tesident #28 off of the toilet elchair, she left the bathroom ish bags she had left in in. She indicated she was or about 5 seconds when #28 scream, she re-entered he found her on the floor. NA sident #28 had fallen while insfer without staff present. A #1 continued. She was made aware of fall risk re in place. She stated the hic record of the NA Daily at of all of the interventions he NA kiosk for Resident th NA #1. The kiosk tion, "Staff to monitor me f assisted to bathroom air/bed. Do not leave me NA #1 acknowledged she int #28 to the bathroom and he retrieved items from the e revealed she had not on was in place for Resident tat she thought Resident #28 ependently and that she only hanging her brief.	F 68	39			

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	S FOR MEDICARE &		0.00			O. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		345015	B. WING		05	5/24/2018
NAME OF PR	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S C	CONVALESCENT NURS			00 MOUNTAIN TOP DRIVE		
			A	SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 689	Continued From pag	e 52	F 689			
		sident #28 had a couple of	1 000			
		ss noted to her head. Nurse				
		essed Resident #28 ' s				
	•	ind noted no concerns with				
	her condition. She o	ments from the physician and				
	-	ssessments with no noted				
	changes in condition					
		ting and shaking early that				
		(18). She indicated Resident the ER for evaluation and				
	was admitted to the l					
	An interview was cor	nducted with Resident #28 on				
		She indicated she had fallen				
		facility. She stated she				
		on and off the toilet and after toileting. The 3/1/18 fall				
		ussed with Resident #28.				
	She stated she was i	in the bathroom, the NA (NA				
		n, and she tried to get up on				
		ed she lost her balance and on the bathroom floor.				
	•	was conducted with the				
		0:10 AM. She stated the				
		interventions related to falls isk for falls and to avoid				
		ne indicated she expected				
		care plan interventions and to				
	implement them at a					
F 758 SS=D	Free from Unnec Psy CFR(s): 483.45(c)(3)	ychotropic Meds/PRN Use)(e)(1)-(5)	F 758			6/15/18
	§483.45(e) Psychotr					
		chotropic drug is any drug that				
		s associated with mental				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 07/03/2018 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE	
		345015	B. WING		_	05/2	24/2018
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURSI	NG HOME INC		00 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203	E		
0(4) 15		ATEMENT OF DEFICIENCIES			PLAN OF CORRECTION		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	• 53	F 758				
	but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic						
	Based on a comprehe resident, the facility m	ensive assessment of a nust ensure that					
	psychotropic drugs ar unless the medication	nts who have not used re not given these drugs n is necessary to treat a diagnosed and documented					
	drugs receive gradual behavioral interventio	nts who use psychotropic I dose reductions, and ns, unless clinically effort to discontinue these					
	unless that medication	ursuant to a PRN order n is necessary to treat a ndition that is documented					
	are limited to 14 days §483.45(e)(5), if the a prescribing practitione appropriate for the PF beyond 14 days, he o rationale in the reside indicate the duration f	er believes that it is RN order to be extended r she should document their nt's medical record and					

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /		COMPLETED
		345015	B. WING		05/24/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
CLAPP'S	CONVALESCENT NURS	ING HOME INC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE COMPLE THE APPROPRIATE DATE
F 758	Continued From page	e 54	F 75	8	
		4 days and cannot be			
	•	attending physician or			
	prescribing practition	er evaluates the resident for			
	the appropriateness of				
		Γ is not met as evidenced			
	by: Based on record roy	iow and staff interview, the		F758	
		iew and staff interview, the as a resident who was on		This plan of correction will	sonvo as tho
		tion for extrapyramidal		facility's allegation of comp	
		Irug induced movement		requirements of 42 CFR, P	
	disorder, for 1 of 3 sa			Subpart B for long term car	
	antipsychotic medica			Preparation and submissio	n of this plan of
	Findings included:			correction is in response to	
				for the May 21st, 2018 surv	-
		ginally admitted to the facility		not constitute an agreemer	
	dementia and unspec	ple diagnoses including		of Clapp's Nursing Home of the facts alleged or the cor	
	-	Data Set (MDS) assessment		conclusions stated on the s	
		ed that Resident #29 had		deficiencies. This plan of c	
		npairment and had received		prepared and submitted be	
	•	lication during the 7 day		requirements of 42 CFR, P	
	assessment period.	0		Subpart B throughout the t	
				stated in the statement of c	leficiencies. In
		t #29 had a doctor's order for		accordance with state and	,
		chotic medication) 50		however, submits this plan	
		blet at 4 PM and at 10 PM		address the statement of d to serve as it's allegation or	
	for unspecified psych	0313.		with the pertinent requirem	•
	Review of Resident #	29's medical records		dates stated in the plan of	
		as no assessment for EPS		as fully completed as of 06	
	completed as of 5/23			Key members of the QAPI	
				to determine the root cause	e of the citation
		AM, the Director of Nursing		related to F758 as well as a	
		ed. The DON stated that		correct the citation. The Co	
		chotic medication should		determined after investigat	
		al Involuntary Movement		facility was failing to perform Abnormal Involuntary Move	
	Scale) test, a test use	ed to assess for EPS.		Apportation involuntary Move	
	-	sion and then every 6 months		assessment in order to get	

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/03/2018 MAPPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345015	B. WING			05/	24/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
				50	00 MOUNTAIN TOP DRIVE			
OLAFF 5	CONVALESCENT NORS			A	SHEBORO, NC 27203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ULD BE COMPLETIC		
F 758	1.0	e 55 Resident #29, it was missed.	F	758	immediate side effects of antipsychoti medications. To achieve compliance of F758, an AIMS assessment was completed for Resident #29 by the Director of Nursing prior to the end of annual survey. All other residents on anti-psychotics were assessed by the Director of Nursing on 06/08/2018 to ensure no AIMS assessment had bee missed, according to the regulations. other areas of concern were found. All other AIMS assessments have been completed according to regulation. The Director of Nursing was also educated the Administrator on 06/08/2018 related the regulations on the completion of A assessments. To ensure substantial compliance with F758 continues, the MDS Coordinator Unit Managers will review the New Physicians Orders Report weekly at minimum for 6 months to verify any residents started on antipsychotics or residents admitted with antipsychotics in have had an AIMS assessment compli- timely in order to assess for immediat side effects of the medication. If substantial compliance is made with the weekly audits, the audit will be reduced monthly for 6 months. If substantial compliance continues to be found, the audit will be discontinued. The Pharm Consultant will also review all residen anti-psychotics monthly to ensure AIM was completed according to regulation This citation and the plan of correction be followed by the facility's QAPI Committee and results of this audit wid discussed in the bi-weekly/monthly	vith the n No l e d by ed to IMS i or new feted e d to e acy ts on IS n. i will		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/0 FORM APPI OMB NO. 093	ROVE	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y	
		345015	B. WING		05/24/2018		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
CLAPP'S	CONVALESCENT NURS	ING HOME INC		00 MOUNTAIN TOP DRIVE SHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO T DEFICIENCE DEFICIENCE DEFICIENCE			ILD BE COMF	X5) PLETIO ATE	
F 758	Continued From page	e 56	F 758	meetings and as needed. The Dire Nursing is responsible for presentir Plan of Correction to the QAPI com Any areas of concern will be addre immediately with the committee's appropriate members.	ng this nmittee.		
F 759 SS=D	Free of Medication E CFR(s): 483.45(f)(1)	rror Rts 5 Prcnt or More	F 759		6/15/	18	
	§483.45(f) Medicatior The facility must ensu						
	percent or greater;	tion error rates are not 5 is not met as evidenced					
	Based on record rev manufacturer 's spec the facility failed to er error rate was 5% or errors of twenty-five (an 8% error rate (Res findings included: 1. Resident #24 was 2/23/1994. Cumulating gastrostomy tube (a t abdominal wall for ad Resident #24 had a p administer metoprolo medication) 25 milligr (diuretic) 20 milligram On 5/22/18 at 2:05 Pl observed during med observed to prepare	cifications and staff interview, hsure that the medication less as evidenced by two (2) 25) opportunities resulting in sident #24 and #48). The admitted to the facility ve diagnoses included tube inserted in the Iministration of nutrition). ohysician 's order to I tartrate (hypertension rams via tube and Lasix hs via tube at 2:00 PM.		F759 This plan of correction will serve as facility's allegation of compliance w requirements of 42 CFR, Part 483, Subpart B for long term care faciliti Preparation and submission of this correction is in response to DHHS for the May 21st, 2018 survey and not constitute an agreement or adm of Clapp's Nursing Home of the tru the facts alleged or the correctness conclusions stated on the statement deficiencies. This plan of correction prepared and submitted because of requirements of 42 CFR, Part 483, Subpart B throughout the time peri stated in the statement of deficiencies accordance with state and federal however, submits this plan of correct address the statement of deficienciencies to serve as it's allegation of compliant	vith es. plan of 2567 does nission th of s of the nt of n is of the od cies. In law, ection to ies and		

Event ID: 4GCC11

Facility ID: 923103

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						D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		345015	B. WING		05	/24/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 759	Continued From page	e 57	F 75	9		
	 Continued From page 57 administered the medications via gastrostomy tube. On 5/22/18 at 2:18 PM, an interview was conducted with Nurse #2 who stated she thought it was all right to crush them together and not administer them one at a time since it was only two (2) medications. She was not aware that they should have been administered separately with a water flush between medications. On 5/23/18 at 12:04 PM, an interview was conducted with the Director of Nursing who stated her expectation was for nursing staff to follow the policy for medication administration via gastrostomy tube which stated if administering more than one medication, flush with 5 cubic centimeters of water between medications. Resident #48 was admitted to the facility on 4/11/18 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). 			with the pertinent requirements as a dates stated in the plan of correction as fully completed as of 06/15/2018 Key members of the QAPI committee to determine the root cause of the of related to F759 as well as a plan to correct the citation. The committee determined the two nurses who may medication errors while being obset the surveyor needed education related either inhaler administration or medication via gastrostomy tube achieve substantial compliance witt all Full-time, Part-Time, PRN and Contracted RNs and LPNs were eco on proper inhalation and gastrostom medication administration by the Di of Nursing prior to 06/13/2018. The education specifically addressed medication administration via gastri tube as well as the time limitations	on and a. ee met citation ade rved by ated to dication e. To h F759, ducated my tube irector ostomy to be	
	by the facility was rew information indicated puffs, wait at least on you are using other in wait at least 1 minute medication and use th Resident #48 had a c for Symbicort (used to patients with COPD) inhaler - 2 puffs twice On 5/23/18 at 9:00 At	"if your prescribed dose is 2 e minute between them. If halers at the same time, between the use of each his drug last". Noctor's order dated 4/11/18 o reduce exacerbation in 160-4.5 microgram (mcg) e a day for COPD. M, Nurse # 4 was observed o pass. She was observed		followed when administering inhale To ensure on-going compliance wit F759, education related to medicat administration related to inhalation gastrostomy tubes will be provided nursing staff yearly. The Director of Nursing or Unit Manager will obser different nurses per week for 4 wee during their medication pass to ens errors are made related to gastrost tube medication administration and inhalation therapy. The Medication Administration audit will be done or shifts, on various halls and will inclu- weekends. The Director of Nursing ensure no medication errors are made	h ion and to all f ve 3 eks sure no omy I n all ude will	

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		MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	8-039 7
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345015	B. WING		05/24/201	8
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC		00 MOUNTAIN TOP DRIVE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPL	LETIO
F 759	observed to administ without waiting at lea On 5/23/18 at 9:50 A interviewed. She sta waited 1 minute betw manufacturer's recor On 5/24/18 at 9:26 A of Nursing (DON) wa that she expected the minute between puffs than 1 puff per the m recommendation.	er 2 puffs of Symbicort st a minute between puffs. M, Nurse #4 was ted that she should have veen puffs per the nmendation. M, interview with the Director s conducted. She stated e Nurse to wait at least 1 s when administering more anufacturer's	F 759	compliance is found during the week audit, the audit will then be reduced to per month for 3 months. If substantia compliance is found after the monthly audits, the audit will be reduced to 5 nurses per quarter, on-going. This cit and the plan of correction will be follo in the facility's QAPI Committee and results of this audit will be discussed the bi-weekly/monthly meetings and a needed. The Director of Nursing will responsible for presenting this Plan of Correction to the QAPI Committee. A areas of concern will be addressed immediately with the committee's appropriate members.	o 3 I / ation wed in as be of ny	
F 842 SS=B	CFR(s): 483.20(f)(5), §483.20(f)(5) Reside (i) A facility may not r resident-identifiable t (ii) The facility may re resident-identifiable t accordance with a co agrees not to use or except to the extent t to do so. §483.70(i) Medical re §483.70(i)(1) In acco professional standard	nt-identifiable information. release information that is o the public. elease information that is o an agent only in ontract under which the agent disclose the information he facility itself is permitted ecords. rdance with accepted ds and practices, the facility al records on each resident	F 842		6/15/1	0

Event ID: 4GCC11

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	
		345015	B. WING			05/	24/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
CLAPP'S	CONVALESCENT NURSI	NG HOME INC					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BEGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
TAG F 842	Continued From page §483.70(i)(2) The faci all information contain regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to hea by and in compliance §483.70(i)(3) The faci record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yea legal age under State §483.70(i)(5) The medi (ii) A record of the res	e 59 lity must keep confidential hed in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance activities, reporting of abuse, violence, health oversight administrative proceedings, ooses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident; ident's assessments;		342			DATE
	provided;	ve plan of care and services					

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	E CONSTRUCTION	(X3) TAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	PLETED
		345015	B. WING		0	5/24/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
CLAPP'S (CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 842	Continued From page	e 60	F 84	2		
	and resident review e		_			
	determinations condu					
		's, and other licensed				
	professional's progres					
		ogy and other diagnostic				
	-	equired under §483.50.				
		is not met as evidenced				
	by: Based on record revi	iew, resident and staff		F842		
		failed to maintain complete		This plan of correction will se	ve as the	
	· · · ·	records for restorative		facility's allegation of complian		
	nursing for two (2) of	three (3) residents		requirements of 42 CFR, Part	: 483,	
	(Resident #4 and Res included:	sident #8). The findings		Subpart B for long term care f Preparation and submission c correction is in response to D	of this plan of	
	1. Resident #4 was r	eadmitted to the facility		for the May 21st, 2018 survey		
	2/16/18. Cumulative			not constitute an agreement of		
		eet, diabetes, dementia and		of Clapp's Nursing Home of th	ne truth of	
	chronic obstructive pu	ulmonary disease(COPD).		the facts alleged or the correct		
	A			conclusions stated on the stat		
		m Data Set (MDS) dated		deficiencies. This plan of con		
		sident #4 was cognitively xtensive assistance with all		prepared and submitted beca requirements of 42 CFR, Part		
		g (ADL) except eating.		Subpart B throughout the time		
		d and he was only able to		stated in the statement of def		
	stabilize with staff ass	sistance. Range of motion		accordance with state and fee		
	was coded as impairr	ment of both lower		however, submits this plan of		
	extremities.			address the statement of defi		
	A poro plan datad 0/0	119 royoolod Desident #4		to serve as it's allegation of co		
		1/18 revealed Resident #4 nursing for transfers and		with the pertinent requiremen dates stated in the plan of cor		
	walking.	and a consister and		as fully completed as of 06/15		
				Key members of the QAPI co		
	On 5/21/18 at 3:49 Pl	M, an interview was		to determine the root cause o		
		lent #4 who stated he was		related to F842 as well as a p	lan to	
		tated his legs just weren't		correct the citation. The comm		
	strong enough for him	n to walk.		determined the MDS Coordin	ator had	
				been insufficiently educated r	- 1 - 4 1 1	

Event ID: 4GCC11

Facility ID: 923103

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					OMB NO. 0938	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	Y
		345015	B. WING		05/24/201	18
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	P CODE	
				500 MOUNTAIN TOP DRIVE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC		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 (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE COMP TO THE APPROPRIATE DA	X5) PLETIC ATE
F 842	Continued From page	a 61	F 84	12		
1 042		sident #4 was referred to the			iovo oubstantial	
				nursing program. To ach		
		ogram for transfers and oals for Resident #4 stated		compliance with F842, the Nursing provided education		
	-	to stand x 10 repetitions with		06/08/2018 to the MDS		
		ard assist two times daily x		the RAI manual related t		
		nd ambulate with rolling		documentation requirem		
		hallway two times daily x		restorative nursing progr		
	seven days a week.			06/15/2018, the Director		
		monthly nursing summary		Nurse Manager will also	audit the facility's	
	check off list or restor	rative nursing progress		current restorative progr	am and identify	
	notes to evaluate the	progress towards		any documentation that	is behind. The	
	restorative nursing ca	are plan goals.		MDS coordinator, after to educated will update the		
	On 5/23/18 at 11:20 A	AM, an interview was		reach compliance.		
		Nurse #1 who stated she				
		torative nursing program		To ensure continued cor	-	
		The nursing assistants were		F842, the Director of Nu	-	
	responsible for carryi			restorative residents per		
		igned residents. When a		months to ensure all doo	•	
		on the restorative nursing		to date with all residents		
		ted the forms for restorative		monitor that the facility's		
		ed the restorative nursing		thoroughly educating the		
		fication sheet, the resident ive nursing and entered what		Coordinator was sufficie compliance will be susta		
		ogram had been initiated in		substantial compliance i		
	the nursing assistant	-		monthly audit, the audit		
	-	ed in the kiosk what had		reduced to quarterly for		
		estorative nursing on their		Should substantial comp	-	
	-	said she completed the		be found, the QAPI com		
	restorative nursing su	-		decide, based on the au		
	monthly and wrote su	immary notes quarterly in		often the audit should be	e done, on-going.	
	-	MDS assessments. She		This citation and the pla		
		nould have had restorative		be followed in the facility		
		leted for March 2018 and		Committee and results of		
	April 2018.			discussed in the bi-weel		
		· · · · ·		meetings and as needed		
	On 5/23/18 at 11:57 A			Nursing is responsible for		
		irector of Nursing. She said,		plan of correction to the		
	once the restorative of	care plan was in place, the		Any areas of concern wi	II DE ADDRESSED	

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					OMB NO. 0938-03 (X3) DATE SURVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345015	B. WING		05/24/2018	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE 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 CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC	
F 842	 daily seven days per expected MDS Nurse day assessment and She said the restoratilist should be comple On 5/23/18 at 2:10 Pl conducted with nursir stated she provided of the day shift (7:00AM exercises with sit to s 2. Resident #8 was a Cumulative diagnose accident (CVA) with fl affecting the right dor weakness. A quarterly Minimum 5/14/18 indicated Restores ambulation occurred period. Balance was a able to stabilize with smotion was coded as upper and lower extrema A care plan dated 5/1 received restorative revealed Restores revealed Restores and the restored restores and the restored rest	hould be done two times week. She stated she #1 to complete a thirty (30) a quarterly summary note. we nursing summary check ted monthly. M, an interview was ng assistant (NA) #2. She are for Resident #4 during -3:00 PM) and performed tand. admitted to the facility 2/7/18. s included cerebrovascular laccid hemiplegia (paralysis) ninant side and muscle Data Set (MDS) dated sident #8 had short and pairment and was in decision-making. She ssistance with transfers. No during the assessment impaired and she was only staff assistance. Range of impairment on one side for	F 842			

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						O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		` '	e survey Ipleted
		345015	B. WING		0	5/24/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC		500 MOUNTAIN TOP DRIVE 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 842	Continued From page	e 63	F 84	2		
	and tactile cues for ir	struction and ambulation to				
		and from the nursing station				
		assistance and gait belt.				
	There was no documentation in the monthly nursing summary check off list or restorative					
	nursing progress note	es to evaluate the progress				
	towards restorative n	ursing care plan goals.				
	On 5/23/18 at 11:20 /	AM. an interview was				
	conducted with MDS Nurse #1 who stated she					
		torative nursing program				
	responsible for carryi	The nursing assistants were				
		igned residents. When a				
		on the restorative nursing				
		ted the forms for restorative the restorative nursing				
	-	ification sheet, the resident				
	care plan for restorat	ive nursing and entered what				
		ogram had been initiated in				
	the nursing assistant	kiosk. The nursing ed in the kiosk what had				
		estorative nursing on their				
		said she completed the				
	restorative nursing su	ummary check off list ummary notes quarterly in				
		MDS assessments. She				
	•	hould have had restorative				
	-	leted for March 2018 and				
	April 2018.					
	On 5/23/18 at 11:57 /	AM, an interview was				
		irector of Nursing. She said,				
		care plan was in place, the				
		should be done two times week. She stated she				
		e #1 to complete a thirty (30)				
	day assessment and	a quarterly summary note.				
	She eaid the restarat	ive nursing summary check	1	1		1

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		ID HUMAN SERVICES			PRINTED: 07/03/2 FORM APPRO
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
		345015	B. WING		05/24/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
CLAPP'S CONVALESCENT NURSING HOME INC			500 MOUNTAIN TOP DRIVE		
CLAPP 5	CONVALESCENT NURS	ING HOME INC		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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
F 842	Continued From page	e 64	F 842		
	list should be comple				
F 865 SS=D	stated she provided of the day shift (7:00AM she assisted Resider ambulation daily and ambulation. She said with ambulation. QAPI Prgm/Plan, Dis CFR(s): 483.75(a)(2)	ng assistant (NA) #2. She care for Resident #8 during I-3:00 PM). NA #2 stated at #8 with transfers and used a gait belt for d Resident #8 was doing well closure/Good Faith Attmpt (h)(i)	F 865		6/15/18
		nt its QAPI plan to the State er than 1 year after the egulation;			
	except in so far as su	ary may not require ords of such committee ich disclosure is related to ch committee with the			
	and correct quality de a basis for sanctions.	by the committee to identify eficiencies will not be used as			
	Based on resident and record review, the fact Committee failed to n procedures and monit	nd staff interviews and cility's Quality Assurance naintain implemented tor the interventions the ce following the recertification		F865 This plan of correction will serve as th facility's allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities.	

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F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			
PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345015	B. WING		05/24/2018
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
ONVALESCENT NURSI	NG HOME INC		500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
Continued From page	9 65	F 86	55	
survey of 4/19/17. The recited during a recer- in areas of Quality of Services at F758 and continued failure of the surveys of record sho- inability to sustain and Assessment and Asse The findings included This citation is cross of F689- Based on record and staff interview, the resident who required 1 staff for toileting from and sustaining a suba- (bleeding in the space tissue covering the bri- hematoma (pool of bluits outermost covering assisted to the bathroo (NA) #1, NA #1 exited items from the residen fell as she attempted from the toilet to her w by staff. This was for for accidents. F758- Based on record the facility failed to as antipsychotic medicat symptoms (EPS), a d	his was for three deficiencies tification survey of 5/24/18 Life at F689, Pharmacy Administration at F842. The e facility during two federal ws a pattern of the facility's d effective Quality urance program. : referenced to: rd review, resident interview, e facility failed to prevent a the extensive assistance of m falling in the bathroom arachnoid hemorrhage e between the brain and the ain) and a subdural ood between the brain and g). Resident #28 was om by Nursing Assistant t the bathroom to retrieve ht's room, and Resident #28 to transfer independently vheelchair while unattended 1 of 5 residents reviewed		Preparation and submission correction is in response to for the May 21st, 2018 sum not constitute an agreement of Clapp's Nursing Homent the facts alleged or the co- conclusions stated on the deficiencies. This plan of prepared and submitted bo- requirements of 42 CFR, F Subpart B throughout the stated in the statement of accordance with state and however, submits this plan address the statement of to serve as it's allegation of with the pertinent requirem dates stated in the plan of as fully completed as of 00 Key members of the QAPP to determine the root cause related to F865 as well as correct the citation. The co- determined they had failed auditing the areas which w previous year's annual su QAPI meetings. Failure to audit these areas caused unable to recognize when not working successfully. compliance with F865, the meet every other week for more closely monitor the a education required for eve- cited. After two months of	o DHHS 2567 rvey and does ent or admission of the truth of prrectness of the statement of correction is ecause of the Part 483, time period deficiencies. In d federal law, n of correction to deficiencies and of compliance nents as of the f correction and 6/15/2018. I committee met se of the citation a plan to ommittee d to continue were cited on the rvey in their o continue to the facility to be systems were To achieve e facility will r two months to audits and ery deficiency
	SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L Continued From page survey of 4/19/17. The recited during a recer- in areas of Quality of Services at F758 and continued failure of the surveys of record shot inability to sustain and Assessment and Assis The findings included This citation is cross of F689- Based on record and staff interview, the resident who required 1 staff for toileting from and sustaining a suba- (bleeding in the space) tissue covering the bri- hematoma (pool of bl- its outermost covering assisted to the bathroo (NA) #1, NA #1 exited fell as she attempted from the toilet to her w by staff. This was for for accidents. F758- Based on record the facility failed to as antipsychotic medicat symptoms (EPS), a d disorder, for 1 of 3 sa	CONVALESCENT NURSING HOME INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 65 survey of 4/19/17. This was for three deficiencies recited during a recertification survey of 5/24/18 in areas of Quality of Life at F689, Pharmacy Services at F758 and Administration at F842. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain and effective Quality Assessment and Assurance program. The findings included: This citation is cross referenced to: F689- Based on record review, resident interview, and staff interview, the facility failed to prevent a resident who required the extensive assistance of 1 staff for toileting from falling in the bathroom and sustaining a subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain) and a subdural hematoma (pool of blood between the brain and its outermost covering). Resident #28 was assisted to the bathroom by Nursing Assistant (NA) #1, NA #1 exited the bathroom to retrieve items from the resident's room, and Resident #28 fell as she attempted to transfer independently from the toilet to her wheelchair while unattended by staff. This was for 1 of 5 residents reviewed	CONVALESCENT NURSING HOME INC ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 65 survey of 4/19/17. This was for three deficiencies recited during a recertification survey of 5/24/18 in areas of Quality of Life at F689, Pharmacy Services at F758 and Administration at F842. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain and effective Quality Assessment and Assurance program. The findings included: This citation is cross referenced to: F689- Based on record review, resident interview, and staff interview, the facility failed to prevent a resident who required the extensive assistance of 1 staff for toileting from falling in the bathroom and sustaining a subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain) and a subdural hematoma (pool of blood between the brain and its outermost covering). Resident #28 was assisted to the bathroom to retrieve items from the resident's room, and Resident #28 fell as she attempted to transfer independently from the toilet to her wheelchair while unattended by staff. This was for 1 of 5 residents reviewed for accidents. F758- Based on record review and staff interview, the facility failed to assess a resident who was on antipsychotic medication for extrapyramidal symptoms (EPS), a drug induced movement disorder, for 1 of 3 sampled residents on	SOUVALESCENT NURSING HOME INC Sou MOUNTAIN TOP DRIVE ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE AC REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAN O CROSS-REFERENCED TO LEACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT TAG PREAD PROVIDERS PLAN O PROVIDERS PLAN O CROSS-REFERENCED TO DEFICIENT TAG Continued From page 65 survey of /19/17. This was for three deficiencies recited during a recertification survey of 5/24/18 in areas of Quality of Life at F689, Pharmacy Services at F758 and Administration at F842. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain and effective Quality Assessment and Assurance program. F 865 The findings included: Subpart B throughout the stated in the statement of accordance with state and f689- Based on record review, resident interview, and staff interview, the facility failed to prevent a resident who required the extensive assistance of 1 staff for toileting from falling in the bathroom and subataining a subarachnoid hemorrhage (bleeding in the space between the brain and the tis outermost covering). Resident #28 was assisted to the bathroom by Nursing Assistant (NA) #1, NA #1 exited the bathroom to retrieve terms from the residents room, and Resident #28 to accidents. Conclusions stated in the plan of audity failed to assess a resident who was on antipsychotic medication for extrapyramidal symptoms (EPS), a drug induced movement disorder, for 1 of 3 sampled residents on

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/03/2018 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345015	B. WING			05	/24/2018
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				50	00 MOUNTAIN TOP DRIVE		
CLAPP'S	CONVALESCENT NURS	ING HOME INC		A	SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 865	interview, the facility and accurate medica nursing for two (2) of (Resident #4 and Res Interview on 5/24/17 Administrator stated s how their systems fai	failed to maintain complete I records for restorative three (3) residents sident #8).	F	865	immediately by the appropriate comm members. Action plans will be initiate correct any areas of concern immedia as well. The facility has a new Administrator of record which became effective in May 2018. The new Administrator will educate all QAPI members on the requirements of an effective QAPI Program to include monitoring the continued success of corrected survey-related deficiencies three F-tags which were cited on both 2017 survey as well as the current su were brought to the QAPI committee 06/15/2018. All new processes put in place to correct the three deficiencies were assessed by the QAPI committee and no areas of concern were found. Committee determined the QAPI prog- related to F865 was brought back in to compliance on 06/15/2018. To ensure on-going compliance with F865, the new Administrator will reviet QAPI Program documents related to F-689, F-842 and F-758 prior to the bi-weekly/monthly QAPI Meetings for year in order to ensure the QAPI prog- is properly monitoring all new process and audits as a result of the state cited deficiencies. The QAPI Meetings are prepared and presented by the Direct Nursing. Although the Administrator is active member of the QAPI Committee the Administrator will now be response for ensuring all areas are being monit prior to the Committee meeting. If substantial compliance is found, the a will be discontinued. Any areas of con- will be addressed upon discovery by	d to ately e . The n the rvey on see The gram so ew all one gram ses ed tor of s an se, ible cored audit ncern	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345015	B. WING			05/	24/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLAPP'S	CLAPP'S CONVALESCENT NURSING HOME INC				00 MOUNTAIN TOP DRIVE SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE			ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 865	Continued From page	2 67	F	865	Administrator.		

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Facility ID: 923103

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