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

PRINTED: 07/26/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345015	B. WING			C 06/14/2023	
NAME OF PROVIDER OR SUPPLIER CLAPP'S CONVALESCENT NURSING HOME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203	1		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
E 000	Initial Comments		E 00	0			
F 000	An unannounced recertification survey was conducted 6/12/2023 through 6/14/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# ZN0O11. INITIAL COMMENTS		F 00	0			
	survey was conducte 6/14/2023. NC00192 NC00198819 were in	complaint investigation of from 6/12/2023 through 011, NC00193472, and exestigated. No deficiencies of the 6 allegations. See					
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	IRE	TITLE		(X6) DATE	

Electronically Signed 06/19/2023

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.