PRINTED: 03/21/2013 FORM APPROVED OMB NO. 0938-0391

CENTER	O LOW MEDICAME OF	MEDICAID SEKAICES				OWR NO	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION i	(X3) DATE SURVEY . COMPLEYED	
		345015	8. WING			02/	07/2013
NAME OF PE	ROMBER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
CLAPPS (CONVALESCENT NH	•		60	DO MOUNTAIN TOP DRIVE		
000	JOHN LEODEN MI			A	SHEBORO, NC 27203		
- (X4) ID	9UMMARY 8T	ATEMENT OF DEFICIENCIES	10	^	PROMOER'S PLAN OF CORRECTION		αŋ
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
						}	
F 221	1 , , , , , , , , , , , , , , , , ,		F	221			•
S\$=0	PHYSICAL RESTRAI	INTS				1	
	₹	right to be free from any					
		posed for purposes of			, disclaimer		
		ence, and not required to			,	ĺ	•
	treat the resident's m	edicai symptome.	1		Clapps convalescent nursin		
					HOME ACKNOWLEDGES RECEIP:		
	This RECHIREMENT	is not met as evidenced			THE STATEMENT OF DEFICIENCE	ES	
	by:	is not met as evidenced			AND PROPOSES THIS PLAN OF	n	,
	1 '	ns, medical racord review			CORRECTION TO THE EXTENT TO THE SUMMARY OF FINDINGS ARE		
		he facility failed to identify	1		FACTUALLY CORRECT AND IN O		•
	the use of raised full	side ralls as a restraint,			TO MAINTAIN COMPLIANCE WIT		
1		symptom for the restraint		•	APPLICABLE RULES AND PROVIS		
		sess the elde reils as a	1		OF QUALITY OF CARE OF RESIDE		
		ne sampled residents with			THE PLAN OF CORRECTION IS		
9	restraints. (Resident		}		SUBMITTED AS A WRITTEN		
		•			ALLEGATION OF COMPLIANCE.		
	The findings included	l:					
ļ	j		1		CLAPPS CONVALESCENT NURSIN		
	Resident #229 was a	dmitted to the facility on			HOME RESPONSE TO THIS STATE	MENT	
	1/19/13 with diagnose	es of Dementia, a fracture of	i		OF DEFICIENCIES AND PLAN OF	o.	
	the left upper arm an	d Congestive Heart Failure.			CORRECTION DOES NOT DENOT		,
			-		AGREEMENT WITH THE STATEM OF DEFICIENCIES NOR DOES IT	I FISH	
		ion Minimum Data Set			CONSTITUTE AN ADMISSION THA	TANY	
1		Indicated Resident #229	1	•	DEFICIENCY ARE ACCRUATE.		
		ssistance for transfer,			FURTHER, CLAPPS CONVALESCE	ENT	
		bility. The use of side rails	-		NURSING HOME RESERVES THE		
		a restraint. Resident #229	}		TO REFUTE ANY DEFICIENCY ON	THE	
	THE SHOP RESIDENCE	ong term memory problems.			STATEMENT OF DEFICIENCIES		<u> </u>
1	Raview of the physics	el therapy plan of care dated			THROUGH INFORMAL DISPUTE		į
1	1/20/13 indicated Re	sident #229 's current level		_	RESOLUTION, FORMAL APPEAL		
[of functioning for tear	raters, toileting, bed mability		•	AND/OR OTHER ADMINISTRATIV	E OR	<u> </u>
	and elt to stand requi	red moderate assistance.			LEGAL PROCEDURES.		
	Resident #229 was a	ble to walk 50 feet with hand	1				,
	held assistance.	ivo nor nor					
					T		
							1
LABORNTORY	DIRECTOR'S OR PROVIDENT	SUPPLIER REPRESENTATIVE'S SIGNATUR	i IE		✓ me		(XI) DATE
	$A \leftarrow III$				A TITLE		fwd pwr E

Any deficiency statement anding with an astertak (*) denotes a delictency which the institution may be excused from correcting providing it is determined that other sefeguards provide sufficient protection to the patients. (See institutions.) Except for nursing homes, the findings stated above are discloseble 80 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 discloseble 14 days following the delet these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is regulate to continued program participation.

FORM CMS-2667(02-95) Previous Versione Obxolete

Event ID: \$4V411

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

PRINTED; 03/21/2013 FORM APPROVED

STATEMENT	OF DEFICIENCIES	IVI DOCUMENTALIS			MB MO	OMB NO. 0936-0391	
AND PLAN C	F CORRECTION	(X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:	I	nple construction NG	(X3) DATE	SURVEY PLETED	
*		345015	B. WNG	,		183 1	
	Royder or Suppuer Convalescent NH			STREET ADDRESS, CITY, STAYE, ZIP CO) U2	/07/2013	
(X4) ID PREFIX TAG	EACH DEFICIENC	atement of deficiencies Y must be preceded by full SC identifying information)	IO PREFIX TAS	PROVIDERS PLAN OF CROSS-REFERENCED TO DEFICIEN	Tion should be The appropriate	(XS) COMPLETION DATE	
F-221	Review of a Social Windicated Resident #2 using hand held assisted Review of the 14 day Resident #229 require transfer, tolleting, amit The use of side ralls assessed on this MDS Review of the care plathe side rails were not for a resident who coulemblate. Interview on 2/5/13 at revealed Resident #229 without staff assistance to bed. The side rall has revealed Resident #229 had be next to the bed. Observations on 2/6/1 Resident #229 was in ralsed. Aide #1 lowere #229. Alde #1 assistation to the side of bed with then transferred to the assistance. Observations for the dia 2/6/13 at 9:00 AM, 2/5/13 at 9:00 AM, 2/	orker's note dated 1/22/13 29 was "semi ambulatory tance secondary to a sling." MDS dated 2/2/13 indicated ad extensiva assistance for oblation and bed mobility. It is a restraint was not is. In dated 1/28/13 revealed care planned as a restraint ald self fransfer and in the slide #1 29 had transferred himself is from the wheelchair back and been left down, and is not sitting in the wheel chair is deen with the side rails of Resident #229 was able to scoot hand held assistance. He wheel chair without steff in the open with the side rails are the side of 2/4/13 at 3:00 PM, 2/6/13 at 1:00 PM, 2/6	F2	Tag # F-22 1 1. The MDS Coordinal Resident #229 immes side rail was placed position. All nursing instructed that side in the down position. Completion Date: 2 2. All residents were as DON and MDS Coordetermine if the use the definition of a residentified as having the definition of restidentified as having the definition of restide rails on all of the Completion Date: 3 3. All side rails were reside rails on all of the Completion Date: 3 4. No further monitor removal of all full-temoval of all ful	tor assessed ediately and the in the down g staff was all was to be left in the control of side rails met straint. Based on idents were side rails that met raints. 28 placed with 1/4-to beds. -15-13 equired due to the agth side rails, not restrict the it of any they do not meet		

1 OWN DIRECTOR (OEAB) LICKIOUS NEW BUT ODSCION

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If continuation sheet Page 2 of 19

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

PRINTED: 03/21/2013 FORM APPROVED

IATEMENT VO PLAN O	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUU	TIPLE CO	N6TRUCTION	OMB NO, 0938-03: (X3) DATE SURVEY		
		INDEASTICATION NOWAEN	A BUILD	NG		Col	MPLETED	
		345015	B. WING			02/07/2013		
	REJIPPRUS RO REDIVO			STREET	'ADDRESS, CITY, STATE, ZIP CODE	~ <u></u>	20112013	
CLAPPS (CONVALESCENT NH			400 W	NOUNTAIN TOP DRIVE EBORO, NC 27203			
(X4) (D	SUMMARY ST	ATEMENT OF DEFICIENCIES		7011				
PREFIX TAG	I (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	10 PREFI TAG	× .	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DOING BE	CAS) GOMPLETH DAYE	
F 221	Continued From page	a 2		104			†	
		t 8:40 AM with MOS nurse	F 2	221			ĺ	
	#1 revealed restraints	were assessed using the						
	MDS. She had not a	sseased the side rails as a	1					
	restraint for Resident	#229. Continued interview						
	revealed the side raite	would not be reaseesed	1					
	until the next MDS wa	a due. MDS nurse #1						
	explained Resident#	229 had improved with	1	f				
	physical therapy, was	more mobile and the side	1	į				
	roils had not been rea	essessed as a restraint,	1	i				
	Continued Interview v	vith MDS nurse #1 revealed		- 1				
	she was informed on	2/7/13, by aide #1, Resident						
ŀ	did not rectifet his av-	ut in bed and the alde rails					ļ t	
	old not result? his mo	vernent in bed. Clarification	İ	i			ĺ	
	with MDS nurse #1 re	vealed she was not		ļ				
	himself independents	ne resident had transferred back to bad on 2/5/13	1				ļ	
į. Į	when the side rails we	are left down Course	!	!			1	
į	Interview with MDS or	irse #1 revealed the side	1	İ			į	
ĺ	rails in a raised position	on would keep Resident		İ			j	
1	#229 from getting in o	rout of the hed	1					
İ	independently.							
	Interview with Adminis	trative staff member #1 on		}				
Í	2/7/13 at 10:00 AM re	vealed the facility was in the						
	process of acquiring n	ew side rails for the "new					Ì	
1	unit" which was the re	hab unit. Resident #229					1	
	resided on the rehab t	unit. Further interview					l l	
- }	revealed, if a fesident	was able to attempt to get					[
1	ovi vi bed, the side te	lls would be a restraint.					1	
	Interview with Physica	Therapist #1 on 2/7/13 at						
	1:03 PM revealed he h	rad completed the initial					1.	
1	evaluation for this real	dent. As of last week, the		1			1	
- 1	residant had two issue	s. One issue was for		1			İ	
[noncompliance with th	e fractured arm; and the		-			1	
1,	second was with safet	y awareness. The resident		ŀ				
transfers a	required stand by assi	st and verbal cues for	l	1			į	
			L .	1			•	

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If continuation shoet Page 3 of 19

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

PRINTED: 03/21/2013 FORM APPROVED

		MEDICAID SERVICES			<u> </u>		D. 0938-0391
AND PLAN O	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345015	B. WHG			200	(#710040
	ROVIDER OR SUPPLIER			51	EET ADDRESS. CITY, STATE, ZIP CODE 00 MOUNTAIN TOP DRIVE SHEBORO, NC. 27203	1 42	(07/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full SC identifying information)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION BHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E E	CONSTELLON DATE
F 272	wanted to do so, the a would not be safe." 483.20(b)(1) COMPR ASSESSMENTS The facility must cond a comprehensive, acc reproducible assessment functional capacity. A facility must make a assessment of a resident assessment of the state. The assessment the following: Identification and dem Customary routine; Cognitive patterns; Communication; Vision;	r and get out of bed if he answer was "yes, but he EHENSIVE fuct initially and periodically surate, standardized ent of each resident's comprehensive lent's needs, using the instrument (RAI) spacified essment must include at aggraphic information;		2272		ken to longer visions ide rail rail	
	Continence; Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of surr the additional assessmances triggered by the Data Set (MOS); and	ng: nd structural problems; I health conditions; status;			restraint. Based on findings no other residents were identified as having si rails that met the definition of restrain Completion Date: 2-28 3. All side rails were replaced with 1 side rails on all of the beds. Completion Date: 3-15-13 4. No further monitor required due or removal of all full-length side rails. 1/4-side rails do not restrict the freed movement of any resident's; therefor do not meet the definition of a restrain	de ats. /4- o the The om of c, they	

FORM CMS-2567(02-49) Previous Varelons Obselete

Event ID: \$4V411

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PRINTED: 03/21/2013 FORM APPROVED

	OF DEFICIENCIES	MEDICAID SERVICES	·		OMB NO. 0938-039		
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		ONSTRUCTION		TE SURVEY MPLETED
·		345015	B. WING				2107/2012
NAME OF PR	NOMBER OR SUPPLIER				TADDRESS, CITY, STATE, ZIP CODE		2/07/2013
CLAPPS (CONVALESCENT NH			ì	MOUNYAIN TOP DRIVE HEBORO, NC 27203	•	
(X4) ID	Summary S	TATEMENT OF DEFICIENCIES	10	- -т-	PROVIDER'S PLAN OF CORRE	TiOu	
PREFIX TAG	REGULATORY OR	OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	COMPLETION DATE
F 272	Continued From pag	e 4	F	272			

	This REQUIREMENT by:	is not met as evidenced				•	
	and staff interviews (comprehensive asse	ons, medical record reviews the facility failed to complete asments to include side rails dant #229) for one of twenty fill comprehensive					**************************************
	The findings included	i :		1			
	1/19/13 with diagnos	admitted to the facility on es of Dementia, a fracture of d Congestive Heart Failure.					, , , , , , , , , , , , , , , , , , ,
	1/20/13 indicated Re- of functioning for tran and sit to stand requi	al therapy plan of care dated sident #229 's current level efers, toileting, bed mobility red moderate assistance, ble to walk 50 feet with hand	E				
	Resident #229 requin transfer, tolleting, am The use of side relle assessed on this MD Areas were not trigge Review of the care pl	an dated 1/26/13 revealed t care planned as a restraint		167131 - G. Carlo-Allerana - Annon - Anno -			

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If continuation sheat Page 5 of 19

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/GUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBERO A. BUILDING COMPLETED 345015 8. WING 02/07/2013 NAME OF PROMDER OR SUPPLIER STREET AUDRESS, CITY, STATE, ZIP CODE 400 MOUNTAIN TOP DRIVE CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 (X4) (D SUMMARY STATEMENT OF DEFICIENCIES PROMDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEOED BY FULL PRÉFIX LEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY Continued From page 5 F 272 Interview on 2/5/13 at 10:25 AM with alde #1 revealed Resident #229 had transferred himself without staff assistance from the wheelchair back to bed. The side rall had been left down, and Resident #229 had been sliting in the wheel chair next to the bed. Observations on 2/6/13 at 10:15 AM revealed Resident #229 was in bed with the side rails raised. Alde #1 lowered the side ralls for Resident #229. Aide #1 assisted Resident #229 in an upright position. Resident #229 was able to acout to the side of bed with hand held assistance. He then transferred to the wheel chair without staff essistance. Observations for the dates of 2/4/13 at 3:00 PM, 2/5/13 at 9:00 AM, 2/5/13 at 1:00 PM, 2/6/13 at 4:00 PM and 2/7/13 at 9:00 AM revealed Resident #229 was tying in bed with both full side rails. Resident #229 exhibited no agitated behaviors. Interview on 2/7/13 at 8:40 AM with MDS nurse #1 revealed restraints were assessed using the

FORM CMS-2867(02-99) Previous Versiona Obserate

in or out of the bed independently, F 279 483.20(d), 483.20(k)(1) DEVELOP

MDS. She had not assessed the side rails as a restraint for Resident #229 and did not consider it a restraint. Continued interview revealed the side rails would not be reassessed until the next MDS was due. MDS nurse #1 explained Resident #229 had improved with physical therapy, was more mobile, and the side rails had not been reassessed as a restraint. Further interview with MDS nurse #1 revealed the side rails in a raised position would keep Resident #229 from getting

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PRINTED; 09/21/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 SYATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BURDING_ 345015 02/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **600 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (AS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LBC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F-279 F 279 Continued From page 6 F 279: COMPREHENSIVE CARE PLANS 1. No immediate action required for the resident affected since Resident # 224 A facility must use the results of the assessment and #158 was discharged at the time of to davelop, review and revise the resident's the survey. comprehensive plan of cere. 2. A list of all residents with pressure The facility must develop a comprehensive care ulcers was developed and care plans plan for each resident that includes measurable were reviewed by the DON to assure objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial their care plans were current and up to needs that are identified in the comprehensive date (reflecting current wound status, treatments etc.). Completion Date: 2assesement. 28-13 The care plan must describe the services that are Weekly skin assessments conducted by to be furnished to attain or maintain the resident's the licensed staff will be reviewed by highest practicable physical, mental, and the MDS Coordinator weekly to psychosocial well-being as required under determine if care plans reflect current §483.25; and any services that would otherwise wound status and/or need revising or be required under §483.25 but are not provided due to the resident's exercise of rights under updating. The MDS nurse will §483.10, including the right to refuse treatment continue to receive and review a copy under §483.10(b)(4). of physician order's to determine if care plan updates are necessary. Completion Date: 3-7-13 This REQUIREMENT is not met as evidenced by: 4. A. Weekly skin assessments will be Based on medical record reviews and staff audited by the DON and/or ADON interview the facility falled to develop a care plan weekly for at least 4 weeks and for the area of pressure ulcers for (Resident compared to the resident care plan to #158) after an assessment of a potential problem assure the plan of care has been of impaired skin Integrity was completed for one updated as needed to reflect the current of three reviews of comprehensive assessments wound status/interventions. This and care plans for residents with pressure vicers. information will be reviewed and The findings included: discussed monthly in the facility QI meetings. Resident #158 was admitted to the facility on Completion Date: 3-7-13

FORM CMS-2587(07-99) Previous Versions Obsolete

9/15/12 with diagnoses of stroke, Hypertension

Event 10; \$47411

Facility ID: 923103

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/21/2013 FORM APPROVED

		MEDIONID SERVICES	, 			OWR NO	. 0938-0391
SYAYEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	F DEFICIENCIES (X.1) PROVIDENSUPPLIENCUA IDENTIFICATION NUMBER:			CON8YNUCTION	(X3) DATE SURVEY COMPLETED	
		345015	B. WING			02/	07/2013
NAME OF PR	ROVICER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE 3P CODE	1 VA	0772010
CLAPPS (CONVALEGCENT NH		600 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203				
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING REFORMATION	ID PRES TAG		Provider's plan of Correction (Each Corrective action Should & Cross-referenced to the appropri Deficiency)	Æ	(X5) COMPLETION DATE
F 279	and Diabetes. Review of the admiss (MDS) dated 9/21/12 required extensive as mobility and tolleting, indicated Resident #1 incontinent of bladder Review of the Care A for the Admission MD pressure ulcars requirecte plan. Review of ulcers revealed a dec with a care plan.	ion Minimum Data Set indicated Resident #158 sistence for transfers, bed Review of the MDS 58 was occasionally rea Assessments (CAAS) S revealed the care area for red review for the need of a the CAAS for pressure islon was made to proceed an dated 9/21/12 revealed	F	279	B. Physician orders will also be reviewed by the DON and/or AI weekly for at least 4 weeks to determine if new treatment orders/changes have occurred. It plans will then be reviewed for a resident with a new pressure ule treatment order or change in treat to assure it has been updated appropriately. This information reviewed and discussed monthly facility QI meetings. Completion Date: 3-7-13	Care any er aument will be	
F 314 SS=D	PM revealed she didned to why this CAA was nurse #2 reported 90's a care plan for the pointegrity due to residuadmission. Further in explained it was miss 483.25(c) TREATMEI PREVENT/HEAL PRIVENT/HEAL	ad and was a mislake. NT/SVCS TO	F	314	F-314 1. No immediate action required for resident affected since Resident and #158 was discharged at the the survey. 2. A team of nurses; DON, ADON Staffing Coordinator conducted assessments on all residents. A resident with pressure ulcers/sk impairment was reported to the who completes the weekly wou assessments. The ADON also a treatment was ordered, and care reflected the current wound state Completion Date: 4-20-13	# 224 time of skin ny in ADON nd assured	

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PRINTED: 03/21/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROMOER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 345015 B. WING 02/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNYAIN TOP DRIVE CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES (X4) 10 PROMDER'S PLAN OF CORRECTION OU) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 314 Continued From page B A) The licensed nursing staff was inservices to promote healing, prevent infection and serviced on accurately completing skin prevent new sores from developing. assessments and reporting impairments to the ADON. Completion Date: 4-20-12 This REQUIREMENT is not met as evidenced B) A new system was developed so Based on medical record reviews and staff that a licensed staff nurse completes interviews the facility failed to assess and monitor skin assessments on all residents pressure ulcers for two of three residents weekly. reviewed with pressure ulcers. (Rasidente #224 Completion Date: 4-20-13 and #158) Findings included; C) The ADON and MDS purse will continue to receive and review a copy of physician orders as another way of 1. Resident #224 was admitted to the facility on communicating new skin 12/27/12 with diagnosis of fractures of the right impairments/treatment revisions upper arm and the left elbow, Insulin Dependent received by the staff nurses. Diabetes and Hypertension. Completion Date: 4-20-13 Review of the "Resident Initial Admission and 4. A) Weekly skin assessments will be Assessment Form " for Resident #224 dated completed by the team of 12/27/12 revealed a skin assessment was administrative nurses, DON, ADON, completed which indicated there were no skin Staff Coordinator, on at least 10 problems on admission. residents who are identified, as at risk for pressure ulcers for 3 weeks to Review of the Admission Minimum Data Set (MDS) dated 1/3/13 indicated Resident #224 assure assessments completed by required extensive assistance of two staff for licensed staff nurses are accurate, then transfers, toiteling, and bed mobility. Review of monthly for 3 months. this MDS indicated bladder function was frequent Completion Date: 4-20-13 inconlinence, bowel function as occasional incontinence and Resident #224 was at risk for

FORM CMS-2587(02-99) Previous Versions Obsolete

pressure ulcers.

Review of a care plan dated 1/3/13 revealed a potential for pressure ulcers due to impaired mobility and incontinence. The approaches

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CENTERS FOR MEDICARE & MEDICAID SERVICES					O. 0938-0391	
	of Deaciencies F Correction	(X1) PROVIDER/SUPPLIER/SLIA IOENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345015	D. WING			Johnson / A
NAME OF PE	RONDER OR SUPPLIER		ята	EET ADDRESS, CITY, BIATE, ZIP CODE	1 02	/07/2013
CLAPPS	CONVALESCENT NH			00 MOUNYAIN TOP DRIVE ISHEBORO, NC 27203		
(X4) ID PREFIX TAG	(ÉACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDEO BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	Provider's Plan of Corre (Each Corrective action shi cross-referenced to the app deficiency)	OULD 8E	(X5) COMPLETION DATE
F 314	Breas and report to a treatment implement implement implement implement instructions to clean bilateral buttocks ever Allevyn (foam dress). Review of the "other chart of nurse's note systems assessment were let. Review of these at 1/9/13, 1/10/13 and documented the skin section L for wounds. Review of "Notes" 1/9/13, 1/10/13 or 1/ assessment of skin passessment of skin passessment of skin passessment of the wounds documentation on the wounds healed of the treatment of the treatment of the wounds healed of the treatment of the wounds healed of the treatment of the treatment of the wounds healed o	the skin for redness or open appropriate staff person for tation. The order dated 1/8/13 gave superficial open areas to ery other day and applying) until the areas healed. Assess" in the electronic is revealed a total body it of Resident #224. The skin ocated under section K and assessments for the dates 1/11/13 revealed Section K is condition was "intact" and documented "none." for the dates of 1/8/13, 11/13 revealed no problems or pressure ulcers. Tracord in the electronic chart and was provided for Resident it record did not assess or it. Review of the electronic revealed in 1/23/13. It 3:00 PM with an nember #1 revealed she did	F 314	DITI DOMESTIC	e wounds centation to leted is will be en monthly ion will be	
	interview with nursest revealed Resident #2	f1 on 2/6/13 at 11:33 AM 224 had exconation to the				

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID: \$4V411

Fadhy 10: 925105

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/GUPPLIER/GLIA (NO) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING _ COMPLETED 345015 B. WING 02/07/2013 NAME OF PROVIDER OR SUPPLIER SYREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN TOP DRIVE CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (S) KOMBJAROD PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE DEFICIENCY F 314 | Continued From page 10 F 314 buttocks on admission. The wounds were explained as a sheer/excorlation. The nurses on the units were to report any wounds to the wound care nurse. Documentation of the wounds on admission, an assessment or measurements were not found in the electronic record. Interview with MDS nurse #1 on 2/6/13 at 3:52 PM revealed she had not visually assessed the wounds. The system for communicating skin conditions included reviewing the chart orders, and/or keeping a copy of the telephone orders. Interview with the facility wound nurse on 2/7/13 at 9:40 AM revealed the nurses were expected to report residents with skin breakdown within 24 hours, except for the weekend. The nurses were to initiate treatment and the wound nurse would follow up with assessment and further treatment. Interview with the facility wound nurse revealed she was not informed about the wounds and had not assessed the wounds. Interview on 2/7/13 at 2:20 PM with administrative nursing staff member #1 revealed her expectation was for the floor nurse to notify the wound nurse of any new skin breakdown. Documentation should have been in the resident's medical record about the wound. It was human error by the

FORM CM8-2587 (02-83) Previous Versions Obsolete

and Diabetes.

nurses.

2. Resident #158 was admitted to the facility on 9/15/12 with diagnoses of stroke, Hypertension

Review of the "Resident Initial Admission and Assessment Form" dated 9/15/12 revealed the skin integrity was assessed as being Intact (no

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO	0.0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER IDENTIFIC		(X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	
		348015	B. WING			02/	07/2013
	CONVALESCENT NH		,	6	LEET ACDRESS, CITY STATE, ZIP CODE OO MOUNTAIN TOP DRIVE LSHEBORO, NG 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	AYEMENT OF DEFICIENCIES Y MUBY BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	EX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ΩĘ	COMPLETION COMPLETION DAYE
F 314	open areas). Review of a 14 Day heated 8/27/12 revealed extensive assistance ambulation. This MC as being occasionally continent of bowel. Review of the Care Afor the Admission MC pressure ulcers required a december of the care plan. Review of the care plan. Review of the care plan problems of potentimpalment. Review of the telephoreveated an order to (Protective Ointment mixture to the coccyphealed. Review of the "other chart of nurse's note: systems assessment were led. Review of these a 10/2/12 through 10/8	Minimum Data Set (MDS) ed Resident #158 required for transfers, toileting and es assessed Resident #158 incontinent of bladder and erea Assessments (CAAS) es revealed the care area for fired review for the need of a fithe CAAS for pressure cision was made to proceed	F	314	OEFICIENCY)		
	Review of the "Notes for the dates of 10/3/	documented "none," " revealed four nursing notes 12, 10/10/12, 10/11/12, and as four notes documented an					

FORM CMS-2567(02-99) Provious Versians Obsoleto

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Facility IO; 923103

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ŧ .		MEDICAUD SERVICES	_,			OMB NO	<u>), 0938-039</u> 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER;	A, AUILO		LE CONSTRUCTION	COMPLETED	
<u> </u>		346015	B. WING			02/	(07/2013
NAME OF PR	OVIDER OR SUPPLIER	_		ST	TREET ADDRESS. CITY, STATE, ZIP CODE		
CLAPPS (CONVALESCENT NH			ł	400 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203		
(X4) IO PREFIX TAG			id Prefi Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACYION SHOULD CROSS-REFERENCED TO THE APPROPR OBFICIENCY)	BE	(KS) COUPLETION DATE
F 314	Continued From page	. 12	_				
1 313	assessment of the wo		F	314	4		<u> </u>
	gegezzingut of the Mc	ound on the coccyx.			į		{
	Review of the Treatm	ent Record for the dates of					<u> </u>
		2/12 revealed a treatment to	}				
ľ	mlx Protective Ointme	ent with EPC and apply to	-				
		lay until healed. The add by each shift beginning	}		1		
ļ	with 3-11 on 10/2/12.						
<u> </u>	documentation of the	wound for review.					
	Review of the "Note Resident #158 was d 12:13 PM.	s ^h for 10/12/12 revealed ischarged on 10/12/12 at					
	not find an esseasme documented for revie	ember #1 revealed she did	منده که دوجنداردود د الاود الاود				
	PM revealed the syst nurses of wound con- information from the li- physician orders. Co this staff member had coccyx wound, had n	urse #2 on 2/5/13 at 3:30 em used to inform the MDS ditions consisted of floor nurses or review of the ntinued interview revealed if not been informed of the ot seen the wound, and did f Resident #158 's wound.					
	at 9:40 AM reveated report any skin break except on the weeker initiate treatment and follow up with assess She was not informed	ility wound nurse on 2/7/13 the nurses were expected to down within 24 hours to her, nd. The nurses were to the wound nurse would ment and further treatment of about Resident #158 's assessed the wounds.					

FORM CM8-4567(02-99) Previous Versions Obsolete

Event ID: 34V411

Facility ID: 823103

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	_	MEDICAID SERVICES			OMB NO	0.0938-0391
AND PLAN O	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE	
		345015	8, WHG		021	07/2013
NAME OF PE	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	1 021	0712010
CLAPPS	CONVALEGCENT NH			500 MOUNTAIN TOP DRIVE ASHEBORO, NG 27203		
(X4) ID PREFIX TAG	{EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREPIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA OEFICIENCY)		(A3) COMPLETION DAYE
F 314	During interview, the wound on the coccyx pressure ulcar since interview on 2/7/13 at nursing staff member was for the floor nurs of any new skin break should have been in	wound nurse explained a would be considered a twas a boney prominence. 2:20 PM with administrative #1 revealed her expectation a to notify the wound nurse known. Documentation the resident's medical record was human error by the	F 314			
F 329 SS≠D	UNNECESSARY DRI Each resident's drug unnecessary drugs. drug when used in ex duplicate therapy); or without adequate mon Indicallons for its use adverse consequence should be reduced or combinations of the n Based on a comprehe resident, the fecility m who have not used a given these drugs unl therapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral interventio	regimen must be free from An unnecessary drug is any cassive dose (including for excessive duration; or nitoring; or without adequate; or in the presence of as which indicate the dose discontinued; or any easons above. The property of a must ensure that residents in the surre that residents are not ease antipsychotic drug are not treat a specific condition cumented in the clinical who use antipsychotic drug who use antipsychotic dose reductions, and	F 329	i. The MDS Coordinator contacted Physician on 2/6/13 and an order written to taper the Seroquel. Torder read to reduce the dosage for one week then discontinue in Physician also gave a diagnosis Senile with Delusions for the us Seroquel. Completion Date: 2-6-13 2. Documentation was reviewed for resident receiving psychotropic medication by the DON to deter a diagnosis was documented for indication of the use of the psychotropic medication. Thes residents were also assessed by determine the continued need for medication. Completion Date: 4-20-12	er was the by half The of c of mine if the to	
					!	

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Event IO:84V411

Facility 10: 923103

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XX) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING _ COMPLETED 345015 9. WING 02/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN YOP DRIVE CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT OF DEFICIENCIES (X4) 10 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PCS) COMPLETION DATE PRÉFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 | Continued From page 14 F 329 3. A) Upon admission, orders are reviewed by the Pharmacist to assure residents receiving psychotropic This REQUIREMENT is not met as evidenced medication have a documented diagnosis for the indication of the usc Based on observations, medical record review, of the medication. and staff interviews the facility failed to provide a Completion Date: 4-20-12 diagnosis for the indication of the use of an antipsychotic medication (Seroquel) and assess the resident 's continued need for the medication B) Pharmacy Consultant reviews each for one of ten residents reviewed for unnecessary resident's drug regimen at least medications. (Resident #229). monthly to determine if medications are necessary, adverse drug reactions The findings included: have occurred/present etc. Based on the findings, recommendations are Resident #229 was admitted to the facility on made to the Physician accordingly. 1/19/13 with diagnoses of Dementla, a fracture of Completion Date: 4-20-12 the left upper arm and Congestive Heart Failure. C) In addition to the Pharmacy Review of the hospital discharge summary dated reviews, the ADON or his/her designee 1/19/13 included the "History of Presenting will review documentation for any illness." Resident # 229 presented to the resident receiving Psychotropic emergency room with a history of worsening medications at least weekly to confusion after taking a pain medication. The determine 1) Documented diagnosis care takers had stopped the medication, but Resident #229 had auditory and visual for the indication of the use of the hallucinations, combativeness, nervousness, and medication, 2) Presence of or lack of panicky when lying flat. Respiratory symptoms of behaviors indicating the use of cough, mucous and shortness of breath began. discontinuance of the psychotropic Resident #229 was brought to the emergency medication, and 3) Compliance with room for avaluation. Admission diagnoses

FORM CMS-2567(02-99) Previous Varsions Obsolele

included toxic metabolic encephalopathy, acute

respiratory fallure, pneumonia, congestive heart

failure, delirium and urinary retention. The discharge summary included 17 dlagnoses, which included *8. Toxic metabolic encephalopathy on admission, which improved during hospitalization.

Event ID: Sevens

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gradual dose reduction (GDR)

Completion Date: 4-20-12

requirements.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DAYE SURVEY IDENTIFICATION NUMBER: A BUILDING_ COMPLETED 345015 B. WNG 02/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, UP CODE CLAPPS CONVALEGCENT NH 500 MOUNTAIN TOP DRIVE A8HEBORO, NC 27203 SUMMARY STATEMENT OF DEPICIENCIES (X4) (Q ID PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (MS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION! TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F 329 Continued From page 15 F 329 4. The DON will monitor the weekly reviews completed by the ADON Review of the admission orders dated 1/19/13 included Saroqual 25 milligrams avery night. weekly for I month, then every two weeks for 1 month, then monthly for 3 Review of the primary physician 's progress months. This information will be notes dated 1/22/13 revealed no diagnosis of reviewed and discussed monthly in the continued delirium. The note included "no facility QI meetings quarterly along behavioral problems " and listed " Domentia" with the Pharmacy report, which as a diagnosis. includes information from the monthly Pharmacy Consultant reviews. Review of the Social Worker's note dated Completion Date: 4-20-13 1/22/13 revealed "He has no psychiatric diagnosis nor does he take any psychotropic drugs. There are no social or behavioral problems, " Review of the admission Minimum Data Set (MDS) dated 1/28/13 indicated Resident #229 Resident #229 had short term and long term memory problems This MDS indicated there were no behaviors, moods or dellrium. Review of the Care Assessment Areas dated 1/26/13 for the area of psychotropic drug use revealed information from the hospital admission. There was no reference to behaviors or delirium on admission or since admission documented in the CAAS. The CAA was blank under the title 1 Routine Drug Evaluation, " This area prompted the assessor to review Seroquel for " appropriateness of use, " Review of the care plan dated 1/26/13 addressed two problems. One of "Cognitive loss/dementla r/t (related to) BIMS acore 7 ... Dx (diagnosis)

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Dementia, hard of hearing " and one of " psychotropic drug use rit dx dementia, apisodes of nervousness, combativeness, auditory and visual hallucinations. The stated goal for these

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Fecally ID: 923103 .

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PRINTED: 03/21/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

OF MEDICAGE & MEDICATO SEKATOES		,			OMB N	O. 0938-0391		
STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDENSUPPLIENCUA IDENTIFICATION NUMBER;			LE CONSTRUCTION	(X3) Date Survey Completed		
		345016	B. WING	i		02	/07/2013	
	CONVALESCENT NH				REET ADDRESS, CITY, STATE, 21P CODE 500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		IO PREF TAC	IX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION COMPLETION	
F 329	Review of the "Notes' the electronic record of behaviors by nurse 2/5/13. Review of the hursing systems assessment incli Cognitive/Mental Statindicated the resident 1/23/13 to 2/5/13, exc Resident #229 was "documentation of bet confusion. This asses answer "Does reside and this was documented the dates listed. Observations on 2/8/Resident #229 followed to shave him, tall set on the toilet and a bath. The alde asked performing each task resident #229 had not the dates in the toilet and a bath. The side asked performing each task resident shook his had observations on 2/5/Resident #229 had no physical behaviors exwas attempted with the lateral was attempted with the lateral	or January 2013 revealed no lored and no behaviors were wring. "and " Other Assess " in revealed no documentation as for the dates of 1/23/13 to a "Other Assess " was a assment of Resident #229, aded Section C: " loss." A review of Section C was alert on the dates of expt for 2/3/12. On 2/3/13 confused, " There was no exit as associated with the sement prompted nurses to ent have behavior issues." Interest of the dates of each in the date of each directions, allowed the sessisted in doing a partial of the resident before all the resident before all the resident before all set and smiled. 13 at 9:00 AM revealed of combative, verbal or chiblied when an interview he resident.	F	328				
	# i revealed she woul	d review the medical record	ļ				j	

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. Facility ID: 923103

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PRINTED: 03/21/2013 FORM APPROVED

		MEDICAID SERVICES					NN 4656 0304
STATEMENT	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:	VS) WAS		DISTRUCTION	(X3) DAI	10. 0938-0391 TE SURVEY MPLETED
	•	345015	8. WNG				
	ROVIDER OR SUPPLIER CONVALESCENT NH		I	600	TADORESS, CITY, STATE, ZIP CODE MOUNTAIN TOP DRIVE		2/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	AYEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IOENTIFYING INFORMATION	IO PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	OATE CONSTRTION (X5)
F 329	Interview on 2/7/13 a #1 revealed she had physician for Resider physician had informed resident was on Seron hospital. The reason due to waiting to see the transfer from the home. The physician sometimes need to comedication after transphysician gave MDS gradual dose reduction 2/7/13. Interview with administrative with administrative with administrative with social vanily sychotic. Behaving the medical record. Interview with social vanily sychotic would not be antipsychotic. Behaving the medical record. Since he was admission to the facility receives the medication revealed a diagnosis indicate the continued to explain for the medication revealed a diagnosis indicate the continued to continued to the facility receives the medication revealed a diagnosis indicate the continued to continued to the facility receives the medication revealed a diagnosis indicate the continued to continued to the facility receives the medication revealed a diagnosis indicate the continued to continued to the facility receives the medication revealed a diagnosis indicate the continued to continued to the facility receives the medication revealed a diagnosis indicate the continued to continued to the facility receives the medication revealed a diagnosis indicate the continued to continued to continued to continued to continued to continue the facility receives the medication revealed the continued to continued to continue the facility receives the medication revealed the continued to continue the facility receives the medication revealed the continued to continue the facility receives the medication revealed the continued to continue the facility receives the recei	determine the reason administered. It 8:30 AM with MDS nurse spoken with the primary at #229 on 2/8/13. The ed MDS nurse #1 the quel due to delirium in the it was not discontinued was the resident's response to hospital to the nursing a indicated residents continue the psychotropic effer until they stabilize. The nurse #1 an order to do a con of the Seroquel beginning astrative nurse #1 on 2/7/13 a diagnosis of only be sufficient for the use of an iors would be documented	£	329			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED; 03/21/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XG) DATE SURVEY IDENTIFICATION NUMBER: A, BUILDING _ COMPLETED 345015 8. WNG 02/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN TOP DRIVE CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 (X4) ID PREFEX SUMMARY STATEMENT OF DEFICIENCIES PROMOER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (XS) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 Continued From page 18 F 329 revealed she usually worked on night shift. Resident # 229 did not have any behaviors exhibited during the night. At times he did not sleep well, but there were no other problems. Occasionally, Resident #229 would forget where he was, but could be redirected and was fine. Interview on 2/7/13 at 12:58 PM with the med aide on the day shift revealed Resident #229 did not refuse care, had no behaviors and was "sweet." Resident#229 took his medications without problems.

FORM CMS-2587(02-99) Provious Versions Obsolete

Event ID:84V411

Facility (D; 923103

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CINICALITING ANIMAINAD PA *DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CONTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 345015 03/06/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **800 MOUNTAIN TOP DRIVE** CLAPPS CONVALESCENT NH ASHEBORO, NC 27203 SUMMARY STATEMENT, OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION! TAG TAG DÉFICIENCY) DISCLAIMER CLAPPS CONVALESCENT NURSING K 000 INITIAL COMMENTS K 000 HOME ACKNOWLEDGES RECEIPT OF THE STATEMENT OF DEFICIENCIES This Life Sefety Code(LSC) survey was AND PROPOSES THIS PLAN OF conducted as per The Code of Federal Register CORRECTION TO THE EXTENT THAT at 42CFR 483.70(a); using the 2000 Existing THE SUMMARY OF FINDINGS ARE FACTUALLY CORRECT AND IN ORDER Health Care section of the LSC and its referenced TO MAINTAIN COMPLIANCE WITH publications. This building is Type III construction. APPLICABLE RULES AND PROVISIONS one story, with a complete automatic sprinkler OF QUALITY OF CARE OF RESIDENTS. system. THE PLAN OF CORRECTION IS SUBMITTED AS A WRITTEN The deficiencies determined during the survey ALLEGATION OF COMPLIANCE, are as follows: NFPA 101 LIFE SAFETY CODE STANDARD K 029 CLAPPS CONVALESCENT NURSING K 029 HOME RESPONSE TO THIS STATEMENT 8S≒D OF DEFICIENCIES AND PLAN OF One hour fire rated construction (with 1/4 hour CORRECTION DOES NOT DENOTE fire-rated doors) or an approved automatic fire AGREEMENT WITH THE STATEMENT extinguishing system in accordance with 8.4.1 OF DEFICIENCIES NOR DOES IT and/or 19.3.5.4 protects hazardous areas. When CONSTITUTE AN ADMISSION THAT ANY the approved automatic fire extinguishing system. DEFICIENCY ARE ACCRUATE. option is used, the areas are separated from FURTHER, CLAPPS CONVALESCENT other spaces by smoke resisting partitions and NURSING HOME RESERVES THE RIGHT doors. Doors are self-closing and non-rated or TO REFUTE ANY DEFICIENCY ON THE field-applied protective plates that do not exceed STATEMENT OF DEFICIENCIES 48 Inches from the bottom of the door are THROUGH INFORMAL DISPUTE RESOLUTION, FORMAL APPEAL permitted. 19.3.2.1 AND/OR OTHER ADMINISTRATIVE OR LEGAL PROCEDURES. This STANDARD is not met as evidenced by: K029 All wedges were remove from the location(s) 42 CFR 483,70(a) During the inspection and later discarded. A magnetic By observation on 3/6/13 at approximately noon the following self-closing door was non-compliant, Door holding device is on order and to be installed. This 4-5-13 specific findings include; door to the kitchen was New device will hold the year door to the kitchen area wedged open. It was also noted that there was a wedge behind the door to the clean linen side of Open and will also be intergrated with the exsisting alarm laundry. System to release upon activation installation will be

LAPORATORY DIRECTOR'S OR PROVIDERUSUPPLIER REPRESENTATIVE'S SIGNATURE

K 060 NFPA 101 LIFE SAFETY CODE STANDARD

SS=D

WHEN THOSE Any deficiency statement ending with an exterisk of 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 evaliable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program perticipation.

K 050

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

Event ID; S4V421

Facility ID: 823103

Complete on or by April 5,2013,

(XII) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDIÇARE & MEDIÇAID SERVICES

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345015		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		B. WING			03/08/2013		
	ROVIDER OR SUPPLIER CONVALESCENT NI	1	•	50	EET ADDRESS, CITY, STATE, ZIP GODE DO MOUNTAIN TOP DRIVE SHEBORO, NC 27203	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
K 050	Continued From page 1 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2		·ĸ	K 050 K 050 on March 19,2013, an inservice for all staff Was held. During this inservice, wa discussed the Purpose and location for all the emergency kill Switches throughout the facility, A routine Q&A Will be added to the monthly fire drill to ansure stoffs Knowledge.		he i	3-19-13
K 062 SS⇒D	42 CFR 483.70(a) By observation on the following fire drawling for the release switch for the exit doors, (nurses NFPA 101 LIFE SARequired automatic continuously maint condition and are in periodically. 19.7 This STANDARD	3/6/13 at approximately noon ill procedure was cific findings include; staff was a operation of the master he operation of the emergency is station 1) FETY CODE STANDARD Sprinkler systems are alned in reliable operating inspected and tested '.6, 4.6,12, NFPA 13, NFPA is not met as evidenced by:	К		<u>K 062</u> A Syr test has been added to the next of inspection and testing which is scheduled for t First week in april, 2013		4-5~13
	noon the following non-compliant, spe from January 2013	on 3/6/13 at approximately sprinkler systems Item was cific findings include; report and January 2012 indicated ar inspection was due to					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES
(X1) PROVIDENSUPPLIER/CLIA

FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBERS	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		345015	B. WING		1	03	/06/2013
NAME OF PROVIDER OR SUPPLIER CLAPPS CONVALESCENT NH			STREET ADDRESS, CITY, STATE, ZIP CODE . 500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From page 2 maintain compliance with NFPA 25, Standard for the inspection, Testing, and Maintenance of water-based fire protection systems. NFPA 101 LIFE SAFETY CODE STANDARD			K 062 K 066 K 066 Metal containers with self closing lids we purchased on March 13,2013 and were place Designated amoking areas. Staff was also insee 3-19-13 as to the proper use for these contain Attackhed is a copy of the invoice of the self Metal containers that were purchased		in the deed on	3-13-13
	42 CFR 483.70(a) By observation on 3 the following smokin non-compliant, spec	s not met as evidenced by: /8/13 at approximately noon ig regulations was ific findings include; a metal i-closing cover into which					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DESIGNATION OF THE PROVIDED IS 100 IN PROVIDED IS 10

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED	
		345016			03,	06/2013
	PROVIDER OR SUPPLIER CONVALESCENT N	4	60	EET AODRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN TOP DRIVE SHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
K 066	ashtrays can be emptied in the smoking area per paragraph 4 above was not provided. (smoking area near laundry) NFPA 101 LIFE SAFETY CODE STANDARD		K 066	•		
SS=D			K 0/6	K 076 The oxygen cylinders in question Were placed by Hospica of Randolph Co. Hospice was notified and the cylinders Were removed. They were also notified that any Future oxygen cylinders must be stored with Tha facility's oxygen. Facility staff was also inserviced On 3-19-13 about proper storage of oxygen cylinder		3-12-13
	42 CFR 463.70(a) By observation on 3 the oxygen storage findings include; ful were stored togethe enclosure, empty cy and designated (wit Empty cylinders sha confusion and delay	0/8/13 at approximately noon was non-compliant, specific I and empty oxygen cylinders er. If stored within the same //lindere.shall be segregated the signage) from full cylinders, all be marked to avoid if a full cylinder is needed 4-3.5,2.2b(2)] (hospice				