STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345015	A. BUILDING _____ B. WING _____	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS CONVALESCENT NH	600 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to identify the use of raised full side rails as a restraint, provided no medical symptom for the restraint use, and did not reassess the side rails as a restraint for one of one sampled residents with restraints. (Resident #229) The findings included: Resident #229 was admitted to the facility on 1/19/13 with diagnoses of Dementia, a fracture of the left upper arm and Congestive Heart Failure. Review of the admission Minimum Data Set (MDS) dated 1/26/13 indicated Resident #229 required extensive assistance for transfer, toileting and bed mobility. The use of side rails were not indicated as a restraint. Resident #229 had short term and long term memory problems. Review of the physical therapy plan of care dated 1/20/13 indicated Resident #229 ' s current level of functioning for transfers, toileting, bed mobility and sit to stand required moderate assistance. Resident #229 was able to walk 50 feet with hand held assistance.	F 221	DISCLAIMER CLAPPS CONVALESCENT NURSING HOME ACKNOWLEDGES RECEIPT OF THE STATEMENT OF DEFICIENCIES AND PROPOSES THIS PLAN OF CORRECTION TO THE EXTENT THAT THE SUMMARY OF FINDINGS ARE FACTUALLY CORRECT AND IN ORDER TO MAINTAIN COMPLIANCE WITH APPLICABLE RULES AND PROVISIONS OF QUALITY OF CARE OF RESIDENTS. THE PLAN OF CORRECTION IS SUBMITTED AS A WRITTEN ALLEGATION OF COMPLIANCE. CLAPPS CONVALESCENT NURSING HOME RESPONSE TO THIS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY DEFICIENCY ARE ACCRUATE. FURTHER, CLAPPS CONVALESCENT NURSING HOME RESERVES THE RIGHT TO REFUTE ANY DEFICIENCY ON THE STATEMENT OF DEFICIENCIES THROUGH INFORMAL DISPUTE RESOLUTION, FORMAL APPEAL AND/OR OTHER ADMINISTRATIVE OR LEGAL PROCEDURES.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Denise Clapp-Campbell — TITLE: Administrator — (X6) DATE: 3-29-13

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.

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CLAPPS CONVALESCENT NH	600 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203

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F 221	Continued From page 1 Review of a Social Worker ' s note dated 1/22/13 indicated Resident #229 was "semi ambulatory using hand held assistance secondary to a sling." Review of the 14 day MDS dated 2/2/13 indicated Resident #229 required extensive assistance for transfer, toileting, ambulation and bed mobility. The use of side rails as a restraint was not assessed on this MDS. Review of the care plan dated 1/28/13 revealed the side rails were not care planned as a restraint for a resident who could self transfer and ambulate. Interview on 2/5/13 at 10:25 AM with aide #1 revealed Resident #229 had transferred himself without staff assistance from the wheelchair back to bed. The side rail had been left down, and Resident #229 had been sitting 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. Aide #1 lowered the side rails for Resident #229. Aide #1 assisted Resident #229 in an upright position. Resident #229 was able to scoot to the side of bed with hand held assistance. He then transferred to the wheel chair without staff assistance. 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 8:00 AM revealed Resident #229 was lying in bed with both full side rails. Resident #229 exhibited no agitated behaviors.	F 221	PLAN OF CORRECTION Tag # F-221 1. The MDS Coordinator assessed Resident #229 immediately and the side rail was placed in the down position. All nursing staff was instructed that side rail was to be left in the down position. **Completion Date: 2-6-13** 2. All residents were assessed by the DON and MDS Coordinator to determine if the use of side rails met the definition of a restraint. Based on findings no other residents were identified as having side rails that met the definition of restraints. **Completion Date: 2-28** 3. All side rails were replaced with 1/4-side rails on all of the beds. **Completion Date: 3-15-13** 4. No further monitor required due to the removal of all full-length side rails. The 1/4-side rails do not restrict the freedom of movement of any resident's; therefore, they do not meet the definition of a restraint.	

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	345015	A. BUILDING _____ B. WING _____	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS CONVALESCENT NH	800 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203

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F 221	Continued From page 2 Interview on 2/7/13 at 8:40 AM with MDS nurse #1 revealed restraints were assessed using the MDS. She had not assessed the side rails as a restraint for Resident #229. 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. Continued interview with MDS nurse #1 revealed she was informed on 2/7/13, by aide #1, Resident #229 could move about in bed and the side rails did not restrict his movement in bed. Clarification with MDS nurse #1 revealed she was not informed by aide #1 the resident had transferred himself independently back to bed on 2/5/13 when the side rails were left down. Further interview with MDS nurse #1 revealed the side rails in a raised position would keep Resident #229 from getting in or out of the bed independently. Interview with Administrative staff member #1 on 2/7/13 at 10:00 AM revealed the facility was in the process of acquiring new side rails for the "new unit" which was the rehab unit. Resident #229 resided on the rehab unit. Further interview revealed, if a resident was able to attempt to get out of bed, the side rails would be a restraint. Interview with Physical Therapist #1 on 2/7/13 at 1:03 PM revealed he had completed the initial evaluation for this resident. As of last week, the resident had two issues. One issue was for noncompliance with the fractured arm; and the second was with safety awareness. The resident required stand by assist and verbal cues for transfers and ambulation. When asked if the	F 221		

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	345013	A. BUILDING _____ B. WING _____	02/07/2013

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CLAPPS CONVALESCENT NH	500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203

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F 221	Continued From page 3 resident could transfer and get out of bed if he wanted to do so, the answer was "yes, but he would not be safe."	F 221		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F-272 Note: The following interventions taken to address F221 resulted in side rails no longer meeting the definition of a restraint. Therefore, there were no care plan revisions necessary 1. The MDS Coordinator assessed Resident #229 immediately and the side rail was placed in the down position. All nursing staff was instructed that side rail was to be left in the down position. Completion Date: 2-6-13 2. All residents were assessed by the DON and MDS Coordinator to determine if the use of side rails met the definition of a restraint. Based on findings no other residents were identified as having side rails that met the definition of restraints. Completion Date: 2-28 3. All side rails were replaced with 1/4-side rails on all of the beds. Completion Date: 3-15-13 4. No further monitor required due to the removal of all full-length side rails. The 1/4-side rails do not restrict the freedom of movement of any resident's; therefore, they do not meet the definition of a restraint.	

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F 272	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews and staff interviews the facility failed to complete comprehensive assessments to include side rails as a restraint for (esident #229) for one of twenty residents reviewed with comprehensive assesements. The findings included: Resident #229 was admitted to the facility on 1/19/13 with diagnoses of Dementia, a fracture of the left upper arm and Congestive Heart Failure. Review of the physical therapy plan of care dated 1/20/13 indicated Resident #229 ' s current level of functioning for transfers, toileting, bed mobility and sit to stand required moderate assistance. Resident #229 was able to walk 50 feet with hand held assistance. Review of the 14 day MDS dated 2/2/13 indicated Resident #229 required extensive assistance for transfer, toileting, ambulation and bed mobility. The use of side rails as a restraint was not assessed on this MDS. The Care Assessment Areas were not triggered for restraints. Review of the care plan dated 1/26/13 revealed the side rails were not care planned as a restraint for a resident who could self transfer and ambulate.	F 272		

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F 272	Continued From page 5 Interview on 2/5/13 at 10:25 AM with aide #1 revealed Resident #229 had transferred himself without staff assistance from the wheelchair back to bed. The side rail had been left down, and Resident #229 had been sitting 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. Aide #1 lowered the side rails for Resident #229. Aide #1 assisted Resident #229 in an upright position. Resident #229 was able to scoot to the side of bed with hand held assistance. He then transferred to the wheel chair without staff assistance. 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 lying 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 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 in or out of the bed independently.	F 272		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 6 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interview the facility failed to develop a care plan for the area of pressure ulcers for (Resident #158) after an assessment of a potential problem of impaired skin integrity was completed for one of three reviews of comprehensive assessments and care plans for residents with pressure ulcers. The findings included: Resident #158 was admitted to the facility on 9/15/12 with diagnoses of stroke, Hypertension	F 279	F-279 1. No immediate action required for the resident affected since Resident # 224 and #158 was discharged at the time of the survey. 2. A list of all residents with pressure ulcers was developed and care plans were reviewed by the DON to assure their care plans were current and up to date (reflecting current wound status, treatments etc.). **Completion Date: 2-28-13** 3. Weekly skin assessments conducted by the licensed staff will be reviewed by the MDS Coordinator weekly to determine if care plans reflect current wound status and/or need revising or updating. The MDS nurse will continue to receive and review a copy of physician order's to determine if care plan updates are necessary. **Completion Date: 3-7-13** 4. A. Weekly skin assessments will be audited by the DON and/or ADON weekly for at least 4 weeks and compared to the resident care plan to assure the plan of care has been updated as needed to reflect the current wound status/interventions. This information will be reviewed and discussed monthly in the facility QI meetings. **Completion Date: 3-7-13**	

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F 279	Continued From page 7 and Diabetes. Review of the admission Minimum Data Set (MDS) dated 9/21/12 indicated Resident #158 required extensive assistance for transfers, bed mobility and toileting. Review of the MDS indicated Resident #158 was occasionally incontinent of bladder. Review of the Care Area Assessments (CAAS) for the Admission MDS revealed the care area for pressure ulcers required review for the need of a care plan. Review of the CAAS for pressure ulcers revealed a decision was made to proceed with a care plan. Review of the care plan dated 9/21/12 revealed no problems of potential for skin integrity impairment. Interview with MDS nurse #2 on 2/5/13 at 3:30 PM revealed she didn't know what happened as to why this CAA was not care planned. MDS nurse #2 reported 90% of the time she would do a care plan for the potential of impaired skin integrity due to residents ' debilitated state on admission. Further interview revealed she explained it was missed and was a mistake.	F 279	B. Physician orders will also be reviewed by the DON and/or ADON weekly for at least 4 weeks to determine if new treatment orders/changes have occurred. Care plans will then be reviewed for any resident with a new pressure ulcer treatment order or change in treatment to assure it has been updated appropriately. This information will be reviewed and discussed monthly in the facility QI meetings. Completion Date: 3-7-13	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	F- 314 1. No immediate action required for the resident affected since Resident # 224 and #158 was discharged at the time of the survey. 2. A team of nurses; DON, ADON, and Staffing Coordinator conducted skin assessments on all residents. Any resident with pressure ulcers/skin impairment was reported to the ADON who completes the weekly wound assessments. The ADON also assured treatment was ordered, and care plans reflected the current wound status. Completion Date: 4-20-13	

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F 314	Continued From page 8 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews the facility failed to assess and monitor pressure ulcers for two of three residents reviewed with pressure ulcers. (Residents #224 and #158) Findings included: 1. Resident #224 was admitted to the facility on 12/27/12 with diagnosis of fractures of the right upper arm and the left elbow, Insulin Dependent Diabetes and Hypertension. Review of the " Resident Initial Admission and Assessment Form " for Resident #224 dated 12/27/12 revealed a skin assessment was completed which indicated there were no skin problems on admission. Review of the Admission Minimum Data Set (MDS) dated 1/3/13 indicated Resident #224 required extensive assistance of two staff for transfers, toileting, and bed mobility. Review of this MDS indicated bladder function was frequent incontinence, bowel function as occasional incontinence and Resident #224 was at risk for 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	F 314	3. A) The licensed nursing staff was in-serviced on accurately completing skin assessments and reporting impairments to the ADON. Completion Date: 4-20-12 B) A new system was developed so that a licensed staff nurse completes skin assessments on all residents weekly. Completion Date: 4-20-13 C) The ADON and MDS nurse will continue to receive and review a copy of physician orders as another way of communicating new skin impairments/treatment revisions received by the staff nurses. Completion Date: 4-20-13 4. A) Weekly skin assessments will be completed by the team of administrative nurses, DON, ADON, Staff Coordinator, on at least 10 residents who are identified, as at risk for pressure ulcers for 3 weeks to assure assessments completed by licensed staff nurses are accurate, then monthly for 3 months. Completion Date: 4-20-13	

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F 314	Continued From page 9 included monitoring the skin for redness or open areas and report to appropriate staff person for treatment implementation. Review of a telephone order dated 1/8/13 gave instructions to clean superficial open areas to bilateral buttocks every other day and apply Allevyn (foam dressing) until the areas healed. Review of the "other Assess" in the electronic chart of nurse's notes revealed a total body systems assessment of Resident #224. The skin assessments were located under section K and L. Review of these assessments for the dates 1/9/13, 1/10/13 and 1/11/13 revealed Section K documented the skin condition was "intact" and section L for wounds documented "none." Review of " Notes " for the dates of 1/8/13, 1/9/13, 1/10/13 or 1/11/13 revealed no assessment of skin problems or pressure ulcers. Reviewed treatment record in the electronic chart revealed the treatment was provided for Resident #224. The treatment record did not assess or measure the wounds. Review of the documentation on the treatment record revealed the wounds healed on 1/23/13. Interview on 2/5/13 at 3:00 PM with an administrative staff member #1 revealed she did not find an assessment of the wound documented for review. Documentation was usually found under the "wound" tab in the electronic chart. Interview with nurse#1 on 2/6/13 at 11:33 AM revealed Resident #224 had excoriation to the	F 314	B) The DON/ADON will compare the list of residents with pressure wounds to the weekly wound documentation to assure they have been completed timely and are accurate. This will be done weekly for 3 weeks, then monthly for 3 months. This information will be reviewed and discussed monthly in the facility QI meetings. Completion Date: 4-20-13	

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F 314	Continued From page 10 buttocks on admission. The wounds were explained as a sheer/excoriation. 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 nurses. 2. Resident #158 was admitted to the facility on 9/15/12 with diagnoses of stroke, Hypertension and Diabetes. Review of the " Resident Initial Admission and Assessment Form " dated 9/15/12 revealed the skin integrity was assessed as being intact (no	F 314		

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CLAPPS CONVALESCENT NH	600 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203

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F 314	Continued From page 11 open areas). Review of a 14 Day Minimum Data Set (MDS) dated 9/27/12 revealed Resident #158 required extensive assistance for transfers, toileting and ambulation. This MDS assessed Resident #158 as being occasionally incontinent of bladder and continent of bowel. Review of the Care Area Assessments (CAAS) for the Admission MDS revealed the care area for pressure ulcers required review for the need of a care plan. Review of the CAAS for pressure ulcers revealed a decision was made to proceed with a care plan. Review of the care plan dated 9/21/12 revealed no problems of potential for/actual skin impairment. Review of the telephone order dated 10/2/12 revealed an order to mix two kinds of creams (Protective Ointment and EPC). Apply the mixture to the coccyx area twice a day until healed. Review of the "other Assess" in the electronic chart of nurse's notes revealed a total body systems assessment of Resident #158. The skin assessments were located under section K and L. Review of these assessments for the dates 10/2/12 through 10/8/12 revealed Section K documented the skin condition was "intact" and section L for wounds documented "none." Review of the "Notes" revealed four nursing notes for the dates of 10/3/12, 10/10/12, 10/11/12, and 10/12/12. None of the four notes documented an	F 314		

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	346015	A. BUILDING _____ B. WING _____	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 12 assessment of the wound on the coccyx. Review of the Treatment Record for the dates of 10/2/12 through 10/12/12 revealed a treatment to mix Protective Ointment with EPC and apply to coccyx area twice a day until healed. The treatment was provided by each shift beginning with 3-11 on 10/2/12. There was no documentation of the wound for review. Review of the " Notes " for 10/12/12 revealed Resident #158 was discharged on 10/12/12 at 12:13 PM. Interview on 2/5/13 at 3:00 PM with an administrative staff member #1 revealed she did not find an assessment of the wound documented for review. Documentation was usually found under the "wound" tab in the electronic chart. Interview with MDS nurse #2 on 2/5/13 at 3:30 PM revealed the system used to inform the MDS nurses of wound conditions consisted of information from the floor nurses or review of the physician orders. Continued interview revealed this staff member had not been informed of the coccyx wound, had not seen the wound, and did not know the stage of Resident #158 ' s wound. Interview with the facility wound nurse on 2/7/13 at 9:40 AM revealed the nurses were expected to report any skin breakdown within 24 hours to her, except on the weekend. The nurses were to initiate treatment and the wound nurse would follow up with assessment and further treatment. She was not informed about Resident #158 ' s wounds and had not assessed the wounds.	F 314		

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F 314	Continued From page 13 During interview, the wound nurse explained a wound on the coccyx would be considered a pressure ulcer since it was a boney prominence. 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 nurses.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 1. The MDS Coordinator contacted the Physician on 2/6/13 and an order was written to taper the Seroquel. The order read to reduce the dosage by half for one week then discontinue it. The Physician also gave a diagnosis of Senile with Delusions for the use of Seroquel. Completion Date: 2-6-13 2. Documentation was reviewed for any resident receiving psychotropic medication by the DON to determine if a diagnosis was documented for the indication of the use of the psychotropic medication. These residents were also assessed by to determine the continued need for the medication. Completion Date: 4-20-12	

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and staff interviews the facility failed to provide a diagnosis for the indication of the use of an antipsychotic medication (Seroquel) and assess the resident's continued need for the medication for one of ten residents reviewed for unnecessary medications. (Resident #229). The findings included: Resident #229 was admitted to the facility on 1/19/13 with diagnoses of Dementia, a fracture of the left upper arm and Congestive Heart Failure. Review of the hospital discharge summary dated 1/19/13 included the " History of Presenting Illness. " Resident # 229 presented to the emergency room with a history of worsening confusion after taking a pain medication. The care takers had stopped the medication, but Resident #229 had auditory and visual hallucinations, combativeness, nervousness, and panicky when lying flat. Respiratory symptoms of cough, mucous and shortness of breath began. Resident #229 was brought to the emergency room for evaluation. Admission diagnoses included toxic metabolic encephalopathy, acute respiratory failure, pneumonia, congestive heart failure, delirium and urinary retention. The discharge summary included 17 diagnoses, which included " 8. Toxic metabolic encephalopathy on admission, which improved during hospitalization. "	F 329	3. A) Upon admission, orders are reviewed by the Pharmacist to assure residents receiving psychotropic medication have a documented diagnosis for the indication of the use of the medication. **Completion Date: 4-20-12** B) Pharmacy Consultant reviews each resident's drug regimen at least monthly to determine if medications are necessary, adverse drug reactions have occurred/present etc. Based on the findings, recommendations are made to the Physician accordingly. **Completion Date: 4-20-12** C) In addition to the Pharmacy reviews, the ADON or his/her designee will review documentation for any resident receiving Psychotropic medications at least weekly to determine 1) Documented diagnosis for the indication of the use of the medication, 2) Presence of/or lack of behaviors indicating the use of discontinuance of the psychotropic medication, and 3) Compliance with gradual dose reduction (GDR) requirements. **Completion Date: 4-20-12**	

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F 329	Continued From page 15 Review of the admission orders dated 1/19/13 included Seroquel 25 milligrams every night. Review of the primary physician ' s progress notes dated 1/22/13 revealed no diagnosis of continued delirium. The note included " no behavioral problems " and listed " Dementia " as a diagnosis. Review of the Social Worker ' s note dated 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 1/26/13 indicated Resident #229 Resident #229 had short term and long term memory problems This MDS indicated there were no behaviors, moods or delirium. 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 " 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/dementia r/t (related to) BIMS score 7 ...Dx (diagnosis) Dementia, hard of hearing " and one of " psychotropic drug use r/t dx dementia, episodes of nervousness, combativeness, auditory and visual hallucinations. The stated goal for these	F 329	4. The DON will monitor the weekly reviews completed by the ADON weekly for 1 month, then every two weeks for 1 month, then monthly for 3 months. This information will be reviewed and discussed monthly in the facility QI meetings quarterly along with the Pharmacy report, which includes information from the monthly Pharmacy Consultant reviews. Completion Date: 4-20-13	

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F 329	Continued From page 16 problems indicated the Seroquel would be effective. Review of the MAR for January 2013 revealed no behaviors were monitored and no behaviors were documented as occurring. Review of the "Notes" and " Other Assess " in the electronic record revealed no documentation of behaviors by nurses for the dates of 1/23/13 to 2/5/13. Review of the " Other Assess " was a nursing systems assessment of Resident #229. This assessment included Section C: " Cognitive/Mental Status. " A review of Section C indicated the resident was alert on the dates of 1/23/13 to 2/5/13, except for 2/3/12. On 2/3/13 Resident #229 was " confused. " There was no documentation of behaviors associated with the confusion. This assessment prompted nurses to answer " Does resident have behavior issues " and this was documented as " none " for all of the dates listed. Observations on 2/8/13 during AM care revealed Resident #229 followed directions, allowed the aide to shave him, take him to the bathroom, he sat on the toilet and assisted in doing a partial bath. The aide asked the resident before performing each task if it was "ok" and the resident shook his head yes and smiled. Observations on 2/5/13 at 9:00 AM revealed Resident #229 had no combative, verbal or physical behaviors exhibited when an interview was attempted with the resident. Interview on 2/5/13 at 3:45 PM with MDS nurse #1 revealed she would review the medical record	F 329		

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F 329	Continued From page 17 for Resident #229 to determine the reason Seroquel was being administered. Interview on 2/7/13 at 8:30 AM with MDS nurse #1 revealed she had spoken with the primary physician for Resident #229 on 2/6/13. The physician had informed MDS nurse #1 the resident was on Seroquel due to delirium in the hospital. The reason it was not discontinued was due to waiting to see the resident's response to the transfer from the hospital to the nursing home. The physician indicated residents sometimes need to continue the psychotropic medication after transfer until they stabilize. The physician gave MDS nurse #1 an order to do a gradual dose reduction of the Seroquel beginning 2/7/13. Interview with administrative nurse #1 on 2/7/13 at 10:15 AM revealed a diagnosis of only Dementia would not be sufficient for the use of an antipsychotic. Behaviors would be documented in the medical record. Interview with social worker #1 on 2/7/13 at 11:30 AM revealed the diagnosis included in the chart that would substantiate the use of Seroquel was due to toxic encephalopathy. The social worker continued to explain Resident #229 was currently not showing any side effects from the medication Seroquel. Since he went into hospital with hallucinations and was relatively stable since admission to the facility, he would continue to receive the medication. Continued interview revealed a diagnosis could not be provided to indicate the continued need for the medication Interview on 2/7/13 at 12:55 PM with nurse #2	F 329		

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F 329	Continued From page 18 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.	F 329		

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	DISCLAIMER CLAPPS CONVALESCENT NURSING HOME ACKNOWLEDGES RECEIPT OF THE STATEMENT OF DEFICIENCIES AND PROPOSES THIS PLAN OF CORRECTION TO THE EXTENT THAT THE SUMMARY OF FINDINGS ARE FACTUALLY CORRECT AND IN ORDER TO MAINTAIN COMPLIANCE WITH APPLICABLE RULES AND PROVISIONS OF QUALITY OF CARE OF RESIDENTS. THE PLAN OF CORRECTION IS SUBMITTED AS A WRITTEN ALLEGATION OF COMPLIANCE.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/6/13 at approximately noon the following self-closing door was non-compliant, specific findings include; door to the kitchen was wedged open. It was also noted that there was a wedge behind the door to the clean linen side of laundry.	K 029	CLAPPS CONVALESCENT NURSING HOME RESPONSE TO THIS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY DEFICIENCY ARE ACCRUATE. FURTHER, CLAPPS CONVALESCENT NURSING HOME RESERVES THE RIGHT TO REFUTE ANY DEFICIENCY ON THE STATEMENT OF DEFICIENCIES THROUGH INFORMAL DISPUTE RESOLUTION, FORMAL APPEAL AND/OR OTHER ADMINISTRATIVE OR LEGAL PROCEDURES. K 029 All wedges were remove from the location(s) During the inspection and later discarded. A magnetic Door holding device is on order and to be installed. This New device will hold the rear door to the kitchen area Open and will also be intergrated with the existing alarm System to release upon activation.Installation will be Complete on or by April 5,2013.	4-5-13
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra Clapp Caudell — TITLE: Administrator — (X6) DATE: 3/22/13

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.

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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 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/6/13 at approximately noon the following fire drill procedure was not-compliant, specific findings include; staff was not familiar with the operation of the master release switch for the operation of the emergency exit doors. (nurses station 1)	K 050	K 050 on March 19,2013, an inservice for all staff Was held. During this inservice, we 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 ensure staffs' Knowledge.	3-19-13
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By documentation on 3/6/13 at approximately noon the following sprinkler systems item was non-compliant, specific findings include; report from January 2013 and January 2012 indicated that a 5 year/10 year inspection was due to	K 062	K 062 A 5yr test has been added to the next quarterly Inspection and testing which is scheduled for the First week in april,2013	4-5-13

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K 062	Continued From page 2 maintain compliance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of water-based fire protection systems.	K 062		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/6/13 at approximately noon the following smoking regulations was non-compliant, specific findings include; a metal container with a self-closing cover into which	K 066	K 066 Metal containers with self closing lids were Purchased on March 13,2013 and were placed in the Designated smoking areas. Staff was also Inserviced on 3-13-13 as to the proper use for these containers. Attatched is a copy of the invoice of the self closing Metal containers that were purchased	3-13-13

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K 066	Continued From page 3 ashtrays can be emptied in the smoking area per paragraph 4 above was not provided. (smoking area near laundry)	K 066		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/8/13 at approximately noon the oxygen storage was non-compliant, specific findings include; full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4-3.5.2.2b(2)] (hospice oxygen storage near nurses station 1)	K 076	K 076 The oxygen cylinders in question Were placed by Hospice of Randolph Co. Hospice was notified and the cylinders Were removed. They were also notified that any Future oxygen cylinders must be stored with The facility's oxygen. Facility staff was also inserviced On 3-19-13 about proper storage of oxygen cylinder tanks	3-12-13