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 _____	05/29/2014

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CLAPPS CONVALESCENT NH	500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203

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F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete an accurate Minimum Data Set assessment for three of twenty-seven sampled residents. The findings were:	F 278	F278 It is the policy of this facility to ensure that the MDS Assessment accurately reflects each resident□s status.	6/24/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/20/2014

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F 278	Continued From page 1 1. Resident # 94 was admitted to the facility on 10/22/10 with diagnoses including Diabetes and Alzheimer ' s. Record review revealed a wound assessment dated 3/11/14 for an unstageable wound on the left heel. This wound was identified on 3/11/14. A wound assessment dated 3/24/14 for a stage 2 wound on the right buttock. This wound was identified on 3/24/14. Review of the Minimum Data Set (MDS) dated 4/19/14 revealed section M was not assessed for any pressure ulcers. Interview with MDS nurse #1 on 5/29/14 at 10:50 AM revealed she missed coding the pressure ulcer on the quarterly MDS. Further interview revealed she was aware he had pressure ulcers and had been following his condition. She explained she did not know how it was missed. 2. Resident #201 was admitted to the facility on 1/2/14 with diagnoses including stroke, hip fracture, anemia and dementia. Record review revealed a wound assessment dated 4/11/14 of a stage 2 pressure ulcer on the sacrum. The wound was identified on 2/28/14. Review of the Minimum Data set dated 3/28/14 revealed section M was not assessed for any pressure ulcers. Interview with MDS nurse #1 on 5/29/14 at 9:47 AM revealed she received wound reports from the Assistant Director of Nursing. She further explained she did not know how it (pressure	F 278	1. Corrective actions taken for those residents found to have been affected by the deficient practice. " On May 29, 2014 the records of residents #94 and #201 were reviewed and revisions made to the assessments to accurately reflect the correct status of each resident related to wounds. " On May 29, 2014, the record of resident #49 was reviewed and revisions made to the assessment to accurately reflect the correct resident status related to falls. " On May 29, 2014 the MDS Nurse was counseled and re-educated on the importance of including pertinent information on each resident□s MDS and of the necessity of reviewing the Wound Log and Fall Logs to ensure accuracy of the MDS and that the status of each resident is accurately reflected. 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: " The Incident/Accident log is in the process of being reviewed for the past three months and the MDS of any resident who sustained a fall will be reviewed and Section J of the MDS pertaining to falls will be reviewed and checked for accuracy to ensure any falls are indicated on the MDS. Any issues	

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F 278	Continued From page 2 ulcer) was missed on the MDS. 3. Resident #49 has cumulative diagnoses which included dizziness. Review of the yearly Minimum Data Set dated 3/11/14 revealed under the section that included whether or not the resident sustained any falls were coded as 0 (zero). Review of the medical record and incident log revealed the resident sustained a fall on 3/4/14 at 6:45 pm. Interview on 5/29/14 at 2:50 pm with MDS #1 revealed she was not been made aware that the resident had a fall on 3/2/14 at 6:45 pm. MDS #1 indicated she only looked at falls from 3/10/14 forward when she used the incident log to determine whether the resident had experienced a fall. Interview on 5/29/14 at approximately 4:15 pm with the director of nurses revealed her expectation was for the MDS coordinator to carefully review the incident logs for all the falls sustained within the time frame of the MDS assessment.	F 278	identified will be revised to reflect the current status of the resident. " The Wound Log is in the process of being reviewed for the past three months and Section M of the MDS will be reviewed to ensure that all wounds are properly indicated on the MDS. If any issues are identified, they will be revised to reflect the resident□s current status. 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: . " The ADON or designee will provide the MDS Nurse with any new falls, wounds or other incidents on a daily basis so that these can be reflected on the MDS and the care plan can be reviewed to ensure accuracy. The MDS Nurse will compile this information with the MDS Schedule so that this information can accurately be reflected on the MDS in a timely manner in conjunction with each resident□s assessment date. " Prior to completing the MDS, the MDS Nurse will also review the Fall Log and Pressure Ulcer Log from the computer, along with daily list provided by the ADON/designee to verify all falls and wounds and any other incidents in the facility to ensure that they are accurately being reported on the MDS in a timely manner according to the MDS schedule.	

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F 278	Continued From page 3	F 278	4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: " QA Audit tools were developed to record the results of the monitoring and ensure compliance. Audits of care plans/MDSs will be conducted by the DON or designee on a daily basis for one week; weekly basis for 4 weeks; every 2 weeks for 30 days and the monthly for 3 months. " The results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual compliance. The facility QA Committee consists of: the Medical Director, Administrator, DON, ADON, Social Worker, and MDS Nurses.	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		6/24/14

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F 280	Continued From page 4 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to update the care plan for Residents #25 and #38 for fall interventions for two of four sampled residents with care plans for falls. The findings included; 1. Resident #25 was admitted to the facility on 3/8/14 with a diagnosis that included, abnormality of gait, dementia, pain in limb, joint pain-pelvis, and hypertension. Review of the Minimum Data Set Assessment (MDS) dated 3/15/14 revealed Resident #25 required extensive assistance in the areas of toileting, bed mobility and transferring. The MDS further revealed Resident #25 was severely cognitively impaired. Review of Resident #25's care plan dated 3/15/2014 revealed a problem of "potential for falls related to history of multiple falls at home, falls in facility during previous admission, fall in facility on 3/13/13 no injury, change in environment, impaired mobility, cognitive impairment, medication use " The goal indicated Resident #25 would have no serious injury related	F 280	F280 It is the policy of this facility to develop a comprehensive care plan within 7 days that is prepared by an Interdisciplinary Team and periodically reviewed and revised after each assessment 1. Corrective action taken for those residents found to have been affected by the deficient practice. " The Care Plan of resident #25 has been reviewed, revised and updated to include all falls and all current fall interventions in place. " An order has been received to discontinue the brace on resident #38 and his care plan has been updated to reflect this change. The alarm has also been discontinued and his care plan has been updated to reflect his change also. 2. Residents having the potential to be affected by the same deficient practice were	

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F 280	Continued From page 5 to falls next 90 days. The approaches included; make sure she is sitting in chair properly - sitting strait up with back and buttocks to back of char - no leaning to side or slumping down - assist her with repositioning as needed, be careful ambulating or transferring when pain is present, notify therapy of any falls, make sure she has on nonskid shoes prior to transfer or ambulation, place frequently used items within reach-ask her what items she would like close by, anticipate her needs-she may not remember to use call light, notify Dr and her son of any falls, assist her with transfers and ambulation-she cannot transfer or ambulate by herself safely, keep her environment free of clutter and safety hazards. The care plan was last updated on 3/26/14 that indicated a fall on 3/26/14 (fall-no injury). No further implementations to approaches were included to the care plan. The facility could not provide any updates or revisions to Resident #25's care plan in regards to falls beyond 3/26/14 A review of Resident #25's nurse's note dated 3/14/14 at 1:10 am revealed a late entry for 11:30pm. Resident heard calling out "woooowhooo", staff found Resident #25 laying on her side on a mat in another resident room beside their bed. The note continued with staff explained to resident that she was not in her room. Fall Scene Investigation Report dated 3/14/14 indicted Resident #25 had an un-witnessed fall attempting to ambulate to and from bathroom without assistance. The incidents contributing factors were confusion related to diagnosis and also darkness and direction into wrong room. Initial interventions put into place to prevent further falls included teaching Resident #25 to	F 280	identified and the following action taken: " The Incident/Accident log is in the process of being reviewed for the past three months and the care plans of any residents who sustained a fall are being reviewed to ensure that all current fall interventions are indicated on the care plan. Any identified issues will be revised and corrected. " As of September 30, 2013, all alarms were discontinued. All resident care plans will be reviewed to ensure accuracy and this intervention has been discontinued from the care plan. 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: . " Following the Fall Scene Investigation Meeting, appropriate interventions identified will immediately be updated on the resident care plan so that all staff is aware of safety interventions for high falls risk residents. The Fall team huddle will initial the worksheet indicating that the care plan has been updated with new interventions. " Licensed Nursing Staff will be reinserviced on the importance of updating the care plan to reflect current interventions so that appropriate care can	

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F 280	Continued From page 6 use of the call light for needs and assistance. The report did not indicate the care plan was updated. A review of Resident #25's nurse's note dated 3/26/14 at 7:22 am indicated Resident #25 was found sitting on floor beside of bed by a nursing assistant. Resident revealed she had gotten up to make the bed. Fall Scene Investigation Report dated 3/26/14 indicted Resident #25 had an un-witnessed fall attempting to ambulating to make up her bed. There was no documented root cause analysis completed in the report nor initial interventions to prevent further falls. The report identified no update to care plan. Review of the facilities Fall Team Meetings notes dated 3/26/14 indicated the summary of the meeting (systemic or operational conditions that may contribute to falls? Any patterns or trends to the resident ' s falls?) revealed, Resident #25 had a fall this AM due to trying to make her bed after the nurse aide had gotten her up. Resident is pleasantly confused mostly during the evening and night time hours. The conclusion revealed, "instructed by staff to make residents bed once she has been gotten up, this way the resident doesn ' t feel obligated to do so. If resident insist on making up her bed, nurse aide can stay in room and assist resident in making her bed." A review of Resident #25's nurse's note dated 4/9/14 at 10:54 pm revealed a late entry for 7:00 pm that said, "called to room by NA, patient noted sitting on floor in front of wheelchair, states 'she was getting up to take her pictures off her board and the chair rolled and she sat right down	F 280	be provided to each resident. " Falls Teams Meeting have been changed from monthly to weekly. During these meetings the Interdisciplinary Team will review the care plan to ensure that all pertinent accident interventions are in place and up to date. Additional interventions may also be recommended at this time and the care plan updated accordingly. " The physician orders will continue to be reviewed on a daily basis and any order requiring care plan updates will be forwarded to the MDS/Care Plan coordinator so that the care plan can be revised and up to date. 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented " QA Audit tools were developed to record the results of the monitoring and ensure compliance. Audits of care plans will be conducted by the DON or designee on a daily basis for one week; weekly basis for 4 weeks; every 2 weeks for 30 days and the monthly for 3 months. " The results of that monitoring will be reviewed and discussed in the monthly QA Committee meeting. The QA committee will assess and modify the action plan as needed to ensure continual	

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F 280	Continued From page 7 in the floor.' The note continued that Resident 25's brakes were not on wheelchair when patient attempted to stand up. Fall Scene Investigation Report dated 4/9/14 said, "Resident #25 had an un-witnessed fall attempting to get up and take her pictures down, did not lock breaks on wheelchair, wheelchair rolled back and patient sad down on floor." Initial interventions put into place included, "took patient out in the hall so staff could watch her." The report further indicated the care plan was updated. Review of the facilities Fall Team Meetings notes dated 4/9/14 indicated the summary of the meeting (systemic or operational conditions that may contribute to falls? Any patterns or trends to the resident's falls?) revealed, "Resident #25 was scheduled to leave this week of the 9th and had been told so by several staff. Resident #25 had already packed all of her things up and she had pictures left on the wall. At 7:00 pm Resident #25 was noted sitting in the floor in front of wheelchair. Staff had been taking up supper trays. Resident #25 did not lock the breaks on her chair, when she stood, she sat down on the floor. The conclusion revealed, "Resident #25 is confused at times. Should not have been told that she was leaving specifically this week. She was adamant that she was taking everything of hers with her." Review of Physician narrative dated 4/23/14 reveled the Resident #25 was seen for follow up chronic medical issues. The narrative continued with Resident #25 was pleasantly demented and had frequent falls. The narrative continued with,	F 280	compliance. The facility QA Committee consists of: the Medical Director, Administrator, DON, ADON, Social Worker, and MDS Nurses.	

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F 280	Continued From page 8 "She has to be reminded not to getup by herself." A review of Resident #25's nurse's note dated 5/3/14 revealed late entry for 5:00 am that indicated a nurse ' s aide looked into room and saw Resident #25 sitting upright on floor beside bed. When asked what she was doing Resident #25 said ' I was going to the bathroom I guess. ' Fall Scene Investigation Report dated 5/3/14 indicted Resident #25 had an un-witnessed fall. The note said, "Resident #25 was in bed all night. Staff on hall doing "rounds" - writer had seen resident in bed approximately 5 minutes earlier. Staff get resident up in wheelchair round this time each morning because she will attempt to get up." Initial interventions put into place to prevent further falls indicated, "will start getting resident up at beginning of round." The report did not indicate the care plan was updated. Review of the facilities Fall Team Meetings notes dated 5/3/14 indicated the summary of the meeting (systemic or operational conditions that may contribute to falls? Any patterns or trends to the resident's falls?) Revealed, "Resident #25 had slept all shift on 3rd. had last been toileted at 12:00 am. Staff had begun to do 5am round. Nurse observed resident attempting to get up. 5 minutes later per nurses statement resident was noted sitting up right beside of bed on floor." The conclusion revealed, "staff aware that she should have been put into her chair when she was attempting to get up. This resident awakens around 5:00 am every morning. The noise level in hallway this (5am) woke resident up. If resident gets up at this time every morning, staff instructed to go ahead with her morning care. Had not been to bathroom since 12:00 am.	F 280		

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F 280	Continued From page 9	F 280		

However, was sleeping so when she awakens, she needs to be toileted."

Review of resident #25's nurse's noted dated 5/22/14 revealed a late entry for 6:00 pm that indicated resident was noted sitting on floor in front of her wheelchair. Stated she was standing up to sit back into her chair and slid to floor. Resident #25 indicated she had hurt her bottom. The note continued with Resident #25 was able to move extremities within normal limits and was assisted back into chair.

Fall Scene Investigation Report dated 5/22/14 indicted Resident #25 had an un-witnessed fall attempting to get up and slide back into chair, fell to floor. Initial interventions put into place included reminding resident to use the call light when transferring. The report did not indicate an update to the care plan.

A review of Resident #25 ' s nurse ' s note dated 5/27/14 at 3:39 am reveled Resident #25 was sitting on floor at foot of bed,. The note continued that Resident #25 indicated she got up to fast and had to sit down on the floor. Resident #25 ' s head was dizzy.

Fall Scene Investigation Report dated 5/27/14 indicted Resident #25 had an un-witnessed fall. The report continued that Resident #25 woke up and had to use the restroom, got up to fast and was dizzy. Patient forgets she needed to call for help to the bathroom. Gait unsteady. Initial interventions put into place to prevent further falls revealed, "patient toileted then put back to bed." The report identified the care plan was updated.

Fall Scene Investigation Report dated 5/28/14

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F 280	Continued From page 10	F 280		

indicted Resident #25 had an un-witnessed fall. The report continued that resident had a tendency to sleep on her side and on the edge of bed, not in the middle of bed. Initial interventions put into place to prevent further falls included, "encourage resident to sleep in middle of bed - monitor this." The note did not identify the care plan was updated.

A review of Resident #25 ' s nurse's note dated 5/29/14 at 12:11 am revealed, "nursing assistant on hall heard sound form resident room, staff into room; resident sitting on floor, bed pad (chuck) half off bed " Resident stated she was not getting out up, she slid out of bed. The note continued that Resident #25 had a tendency to sleep on edge of bed.

Interview with the Assistant Director of Nursing (ADON) on 5/29/14 at 2:03pm revealed the facility was utilizing a new fall program. Whoever located a resident on following a fall would fill out a fall screen investigation packet within 15 minutes of the fall. The nurse that is responsible for the resident would gather all staff that were on the hall and a root cause analysis is determined. The fall huddle team would then come up with initial interventions that would be used to prevent further falls. An episodic care plan is then developed and put into the chart by the nurse. The fall screen team discusses the falls in monthly Quality assurance meeting held monthly. The fall screen team consisting on the MDS coordinator, Director of nursing and department heads. Interventions that had been put into place following the fall are discussed by the team to determine if they were appropriate interventions. The ADON revealed the interventions developed on the fall screen investigation report are note

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F 280	Continued From page 11 added to the care plan and should be. Interview with the MDS coordinator on 5/29/14 at 2:29 pm revealed care plans are updated by the physician order sheets. The MDS coordinator further revealed she becomes aware of need updates as evidenced by walking down the hall and noticing something new or word of mouth by staff and residents. When a fall occurs the nurse would have an immediate huddle. The huddle consists of the individuals that were around the scene at the time of the incident. A monthly fall team meeting is conducted with lead staff members. During the monthly fall meeting the interventions that the nurse come up during the initial huddle are discussed. The fall team would then develop additional interventions or make revisions to the interventions put into place to determine whether they are appropriate. The MDS coordinator further indicated that in the instance there are multiple or frequent falls that she would write the updates directly on the care plans. The MDS coordinator indicated Resident #25's care plan was not updated with new interventions to prevent falls and was not due for an updated until June. It was the responsible of the nurse to communicate the new interventions that are put into place following a falls. Interview with Nurse Aide (NA) #1 on 5/29/14 at 3:07 pm revealed Resident #25 was more confused at night and wants to get up. Interview with NA #1 further indicated that Resident #25 rarely utilizes her call light and gets the attention of staff by calling out when staff walks by. The NA communicated she becomes aware of new interventions to care plans by communication from the responsible nurse. NA#1 could not recall any new interventions to Resident #25's	F 280		

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 _____	05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS CONVALESCENT NH	500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203

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F 280	Continued From page 12	F 280		

plan of care in regards to falls. The NA could indicate the resident was to have a low bed with alarms.

Interview with NA #6 on 5/29/14 at 3:12 pm revealed Resident #25 the resident typically attempted to get up at night and attempt to walk. NA#6 indicated that she would attempt to stop the resident from standing and prompt the resident to remain seated. NA#6 stated she does not look at care plans to determine changes with the residents. NA#6 indicated that she in informed of changes in the resident ' s plan of care by word of mouth from the nurses or NA's that are coming off shift. NA#6 stated Resident #25 usually wants to go to the bathroom or is looking for her husband. NA#6 was not aware of any changes to Resident #25 ' s care plan in regards to fall prevention.

Interview with Nurse #1 on 5/9/14 at 3:32 pm revealed resident #25's falls occurred during 3rd shift. Resident #52 typically wants to go home after supper. Nurse #1 continued that Resident #25 does like to get up without assistance. Nurse #1 stated, "Resident #25 is very fortunate she has not had an injury." The nurse continued that following an incident the NA or staff that located the incident complete an incident report. All parties involved in the incident report research ways to prevent the further falls. Nurse #1 stated that she looks at the resident care plans to identity if any changes have been made to the care plans interventions. Nursing assistants don ' t have the section on the electronic system used that includes the interventions put into place on the incident reports. Nursing aides are kept abreast of any changes by the nurse that is responsible for the resident. Nurse #1 revealed

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F 280	Continued From page 13	F 280		

she was not aware of any interventions added to Resident #25's care plan to prevent falls.

Interview with the Administrator on 5/29/14 at 3:42 pm revealed it was her exception that care plans have newly implemented interventions to attempt to prevent falls. It was further the expectation of the administrator that each fall be addressed by the falls team. The falls are addressed through a falls committee that are to identity falls and look for trends to minimize falls. The Administrator indicated that she was aware that Resident #25 had frequent falls but was unaware that Resident #25 had an increase in falls for the month of May 2014.

2. Resident #38 was admitted to the facility on 6/3/11 with diagnosis of hypertension.

Care plan review revealed a problem of potential for falls related to a history of falls dated 4/17/14. The interventions for this problem included use of a seat pad alarm that was dated 5/9/12 and use of a back brace dated 4/17/14.

Interview with Resident #38 on 5/28/14 at 4:25 PM and again on 5/29/14 at 9:00 AM revealed he was not wearing his brace. He stated the staff did not offer to apply the brace. Observations on these dates revealed he did not have an alarm in his wheelchair.

Interview with the Assistant Director of Nursing on 5/29/14 at 9:29 AM revealed Resident #38 had been on the restorative program. The brace was no longer appropriate. The brace was discontinued and there was a note in the chart regarding the brace. Continued interview

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F 280	Continued From page 14 revealed she had talked to therapy for an order related to the brace being discontinued. The order was not written. The MDS would have received a copy of that order if it had been completed. Interview with the MDS nurse #1 on 5/29/14 at 9:37 AM revealed she would be informed of any changes in restorative or therapy during the medicare meetings. If a resident was discontinued, or had changes in the plan of treatment, she would be informed at that time. She did not remember being informed the brace was discontinued. She had gone through the care plans and updated when the alarms were discontinued in the facility. She did not know how Resident #38 ' s alarm was missed.	F 280		