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 _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS CONVALESCENT NH	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 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 278 SS=D	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 interview with staff and record review the facility failed to accurately assess Resident #16's wandering behavior. This was evident in 1 of 3 residents sampled for accidents. Findings included:	F 278	F278 ASSESSMENT ACCURACY 1. Corrective actions taken for those residents found to have been affected by	5/12/16

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

Electronically Signed | 05/05/2016

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F 278	Continued From page 1 Resident #16 was admitted to the facility on 3/18/14 has cumulative diagnoses which included hypertension and dementia. Review of the Minimum Data Set assessment tool dated 2/3/16 revealed the resident was coded as wandering in dangerous places. Review of the interdisciplinary progress notes dated 1/6/16 through 2/3/16 revealed Resident #16 had not wandered into any dangerous places. Review of the social worker note dated 2/3/16 revealed no incidents with Resident #16 wandering into dangerous places. Interview on 04/13/2016 at 9:55AM with the Assistant Director of Nurses (ADON) and the Administrator was held. The ADON indicated Resident #16 wears a wander guard bracelet because she was initially admitted to the facility with exit seeking behavior. However, since she has adjusted to the facility she no longer has exit seeking behavior. Interview on 04/13/2016 at 3:45 PM with the Director of Nurses (DON) revealed the coding reflecting wandering in dangerous places was a transcription error by the social worker (SW). Further interview revealed the expectation that the MDS would be accurate. Interview on 04/14/2016 at 9:32 AM with the SW (who coded the Wandering Section of the MDS) revealed she had not recognized Resident #16 behavior as wandering. Continued interview indicated she had reviewed the nurses ' notes	F 278	the deficient practice. " On 4/18/16 a modification to Resident # 16□s MDS with ARD 2/3/16 was completed correcting Section E0900, by MDS Coordinator. The modified MDS was transmitted and accepted into the QIES database on 5/2/16. 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: " On 4/28/16 30 Section E0900 of the MDS were reviewed for all residents by the Director of Nursing 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: " Social worker and MDS Coordinator were counseled on importance of accurately coding MDS data by the Director of Nursing " All MDS team members responsible for completing sections of the MDS assessment were reminded by the Director of Nursing to double check their sections after completing them and before closing the MDS assessment to assure the coding is accurate. MDS team members MDS Coordinators, Social Worker, and Dietary Manager. Date of completion: 4/28/16 4. How the corrective actions will be	

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F 278	Continued From page 2 and interview staff but there was no mention or concern about the behavior of wandering in dangerous places. The SW indicated she just coded the MDS incorrectly.	F 278	monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: 5 MDS assessments will be reviewed each week for coding accuracy by the DON and or designee. This will be done every week for 4 weeks, then taper to monthly for 2 months. QA Audit tools were developed to record the results of the monitoring. " 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. Date of Completion: 5/12/16 F315 CATHETER CARE 1. Corrective actions taken for those residents found to have been affected by the deficient practice. " On 4/13/16 the catheter was secured by placing a Velcro strap on thigh of resident #62.- by the Licensed Nurse. " On 4/13/16 the Residents Nurse and Nursing assistant were re- in serviced on policy regarding leg strap use with	

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F 278	Continued From page 3	F 278	indwelling catheter by the Director of Nursing 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: " On 4/13/16 all Residents with indwelling catheters were assessed by the Director of Nursing to determine if the catheter was appropriately secure. All residents were found to have catheter tubing secured appropriately. 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: . All Licensed Nurses and Nursing Assistants will be given a copy of the policy and procedure for use of leg strap with Residents having an indwelling catheter by the Assistant Director of Nursing. Date of Completion: 5/12/16 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented:	

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F 278	Continued From page 4	F 278		

" Residents with indwelling catheters will be assessed 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 to leg bands are in place. QA Audit tools were developed to record the results of the monitoring.

" 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.

Date of Completion: 5/12/16

F323

ENVIRONMENT FREE OF ACCIDENT/HAZARDS

1. Corrective actions taken for those residents found to have been affected by the
deficient practice.

" On 4/13/16 the can of disinfectant/deodorant was removed from the handrail outside room 714 and the handrail on 500 and 700 halls.
" On 4/13/16 the Housekeeping Supervisor re-inserviced Housekeeping staff on proper storage of

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disinfectant/deodorant supplies.

2. Residents having the potential to be affected by the same deficient practice were
identified and the following action taken:

" On 4/13/16 all hallways were inspected by the Housekeeping Manager for improper storage of disinfectant/deodorant supplies. There were no other instances of improperly stored disinfectants or hazardous material found.

3. Measures or systemic changes put in place to ensure the corrective actions do not
reoccur:

" On 4/13/16 the Housekeeping Supervisor re-inserviced Housekeeping staff on proper storage of disinfectant/deodorant supplies.

Date of Completion: 4/13/16

4. How the corrective actions will be monitored to ensure the deficient practice will
not reoccur, i.e. quality assurance measures implemented:

" Monitoring will be conducted by Housekeeping Supervisor or designee to ensure hazardous materials are stored

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F 278	Continued From page 6	F 278	out of the reach of Residents. Monitoring will be performed on a daily basis for one week; weekly basis for 4 weeks; every 2 weeks for 30 days and the monthly for 3 months to determine disinfectant/deodorant supplies being stored properly. QA Audit tools were developed to record the results of the monitoring. " 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 Date of Completion: 5/12/16	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff and resident interviews the facility failed to secure the resident ' s indwelling urinary catheter to	F 315	F315 CATHETER CARE	5/12/16

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F 315	Continued From page 7 prevent complications of an indwelling urinary catheter for one of two resident ' s reviewed (Resident #62). Findings Included: Resident #62 was readmitted to the facility on 12/9/15 with the following diagnosis of heart failure, Parkinson's disease, and neurogenic bladder. The Resident ' s Minimal Data Set (MDS) dated 3/14/16 revealed resident #62 was cognitively intact. The resident had an indwelling urinary catheter and was occasionally incontinent of bowel. Resident #62 required extensive assistance with bed mobility, dressing, toilet use and personal hygiene. The resident was on hospice care. Resident #62 had a care plan in place dated 3/17/16 for " complications related to urinary indwelling catheter " . Interventions included for urinary indwelling catheter to be changed monthly and as needed, secure catheter to thigh with leg strap or tape to keep tension off of tubing, keep collection bag below the level of the bladder to prevent urine from back flowing into bladder, check tubing for kinks and untangle as needed, keep catheter bag off the floor, catheter care every shift, empty catheter drainage bag and record output every shift, notify physician of fever, pain, blockage of catheter or cloudy, bloody or foul smelling urine and to place drainage bag in a catheter cover bag when up in chair and out of facility. An observation of the Resident ' s urinary indwelling catheter was made on 4/13/16 at 10:27 AM. Nursing Assistant (NA) #1 provided incontinence care and urinary catheter care to the resident while Nursing Assistant (NA) #2 assisted resident with turning in bed. The Resident ' s urinary indwelling catheter was cleaned properly	F 315	1. Corrective actions taken for those residents found to have been affected by the deficient practice. • On 4/13/16 the catheter was secured by placing a Velcro strap on thigh of resident #62.- by the Licensed Nurse. • On 4/13/16 the Residents Nurse and Nursing assistant were re- in serviced on policy regarding leg strap use with indwelling catheter by the Director of Nursing 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: • On 4/13/16 all Residents with indwelling catheters were assessed by the Director of Nursing to determine if the catheter was appropriately secure. All residents were found to have catheter tubing secured appropriately. 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: • All Licensed Nurses and Nursing Assistants will be given a copy of the policy and procedure for use of leg strap with Residents having an indwelling	

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F 315	Continued From page 8 and the urinary catheter drainage bag was below the resident ' s bladder and hanging on the left side of the bed. There was no type of device that secured the resident ' s indwelling urinary catheter to her leg. There was slight tension noted on the tubing of the resident ' s urinary catheter when the resident was assisted by NA #2 with turning in bed to be cleaned. Resident #62 was interviewed on 4/13/16 at 10:44 AM. The resident stated that she did not have a urinary catheter securing device on her leg today. She stated sometimes she would have one and other times she would not. She stated she does not know who was in charge of making the decision to leave it on. Nurse #1 was interviewed on 4/13/16 at 12:23 PM. She stated the urinary catheter bag should be below the resident bladder and hanging on the bed. There was a Velcro piece that would be put around the catheters and wrapped around the resident ' s thigh so the urinary catheter does not pull on the resident. She stated the nurse was usually the person who would put the Velcro band on the resident leg. Another observation was made of the Resident ' s urinary catheter on 4/13/16 at 12:31 PM. Nurse #1 was present. The resident was in bed. There was not a urinary catheter securing device anchored to the resident ' s thigh. Nurse #1 stated the resident needed a urinary catheter leg strap and she would go get one. Resident #62 was interviewed again on 4/13/16 at 12:34 PM. The resident stated that it had been at least a week since there has been a strap on her leg to hold the urinary catheter. On 4/13/16 at 12:34 PM, Nurse #1 applied a Velcro strap to the resident's left thigh to secure the urinary indwelling catheter. The Director of Nursing was interviewed from	F 315	catheter by the Assistant Director of Nursing. Date of Completion: 5/12/16 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: • Residents with indwelling catheters will be assessed 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 to leg bands are in place. QA Audit tools were developed to record the results of the monitoring. • 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. Date of Completion: 5/12/16	

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F 315	Continued From page 9 4/13/16 at 1:28 PM. She stated that her expectation was for the Nursing Assistant to provide perineal care and the urinary tubing should be secured to the resident leg. The urine should be monitored, including output and to check to ensure the urinary catheter was not blocked. The strap/securing device for the urinary catheter may have been an oversight from staff for this resident.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and review of facility policy the facility failed to ensure hazard chemicals were stored out of the reach of residents as evidence by leaving disinfectant/deodorant spray cans on top of the handrails in 2 of 7 hallways (500 and 700 hall). Findings Included: The Material Safety Data Sheet (MSDS) for "Smooth" (Disinfectant/Deodorizing cleaner) provided by the facility, was classified as a health hazard material. The MSDS noted skin contact and inhalation as the primary route of entry. The MSDS specified eye contact could cause severe	F 323	F323 ENVIRONMENT FREE OF ACCIDENT/HAZARDS 1. Corrective actions taken for those residents found to have been affected by the deficient practice. • On 4/13/16 the can of disinfectant/deodorant was removed from the handrail outside room 714 and the handrail on 500 and 700 halls. • On 4/13/16 the Housekeeping	5/12/16

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F 323	Continued From page 10 irritation, pain and discomfort, excess blinking and tear production and redness and swelling of the conjunctiva. Skin contact could cause brief to severe irritation with pain, local redness and swelling. Inhalation causes irritation to the respiratory tract. Ingestion could cause headache, dizziness, incoordination, nausea, vomiting, diarrhea and general weakness. 1a) On 04/11/2016 10:55 AM, during the initial tour of the facility a 17 oz spray can of a disinfectant/deodorant was observed unsecured and easily accessible on top of the handrail outside room 714. During an observation on 04/12/2016 at 1:40 PM, a 17 oz. spray can of a disinfectant/deodorant was unsecured and easily accessible on top of the handrail outside room 714. The spray can of disinfectant/deodorant was again observed unsecured and easily accessible on top of the handrail outside room 714 on 04/13/16 at 8:40 AM. Residents were noted to be walking up and down the hallway as well as rolling themselves in their wheelchairs. During an observation on 04/13/2016 at 3:01 PM, the 17 oz. spray can of a disinfectant/deodorant was unsecure and easily accessible on top of the handrail outside room 714. 1b) On 04/12/2016 at 1:30 PM, a 17 oz. spray can of a disinfectant/deodorant was observed unsecured and easily accessible on top of the handrail outside room 501. Residents were noted to be walking up and down the hallway. During an observation on 04/13/16 9:30 AM, a 17	F 323	Supervisor re-inserviced Housekeeping staff on proper storage of disinfectant/deodorant supplies. 2. Residents having the potential to be affected by the same deficient practice were identified and the following action taken: • On 4/13/16 all hallways were inspected by the Housekeeping Manager for improper storage of disinfectant/deodorant supplies. There were no other instances of improperly stored disinfectants or hazardous material found. 3. Measures or systemic changes put in place to ensure the corrective actions do not reoccur: • On 4/13/16 the Housekeeping Supervisor re-inserviced Housekeeping staff on proper storage of disinfectant/deodorant supplies. Date of Completion: 4/13/16 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: • Monitoring will be conducted by	

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F 323	Continued From page 11 oz. spray can of a disinfectant/deodorant was unsecured and easily accessible on top of the handrail next to the door to "Annie's Soap Shop" which was located on 500 hall. On 04/13/2016 at 3:08 PM, a 17 oz. spray can of a disinfectant/deodorant was observed unsecured and easily accessible on top of the handrail outside room 501. During an interview on 04/13/2016 at 3:12 PM, the Housekeeper stated the chemicals were kept on the housekeeper's cart when not in use and the carts were locked. The Housekeeper specified that no chemicals were to be kept out in the halls. The Housekeeping Supervisor was interviewed on 04/13/2016 at 3:16 PM. The Housekeeping Supervisor stated the cleaning chemicals were supposed to be kept locked in the Janitor's closet or were kept in the equipment room. During an interview on 04/14/2016 9:02:36 AM, the Administrator said she expected cleaning chemicals to be locked up and not be left sitting out in the hall.	F 323	Housekeeping Supervisor or designee to ensure hazardous materials are stored out of the reach of Residents. Monitoring will be performed on a daily basis for one week; weekly basis for 4 weeks; every 2 weeks for 30 days and the monthly for 3 months to determine disinfectant/deodorant supplies being stored properly. QA Audit tools were developed to record the results of the monitoring. • 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 Date of Completion: 5/12/16	