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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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
E 000	Initial Comments An unannounced Recertification survey was conducted on 07/22/19 through 07/25/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #L4LG11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and Complaint Investigation Survey was conducted on 07/22/19 through 07/25/19. Four of the four allegations were not substantiated.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636		8/22/19

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

Electronically Signed | 08/10/2019

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 636	Continued From page 1 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to comprehensively assess Resident	F 636	This plan of correction will serve as the facility's allegation of compliance with	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 636	Continued From page 2 #72's for the Minimum Data Set, Section C in the area of cognition and mood for 1 of 19 sampled residents. Findings included: Resident #72 was admitted to the facility on 4/12/18 with the diagnosis of depression. Resident #72 ' s care plan dated 4/9/19 revealed a need to monitor for adverse reactions to psychotropic drug use (anti-anxiety and anti-depressant) and behavior. Medication was to be administered as ordered and to monitor mood, behavior and cognitive status. Resident #72 ' s annual comprehensive Minimum Data Set (MDS) dated 4/9/19 revealed Section "C" Cognitive Patterns and mood was "not assessed ' signed by MDS Coordinator #2 on 4/16/19. On 7/24/19 at 2:35 pm an interview was conducted with MDS Coordinator #2 who stated she completed Resident #72's annual MDS dated 4/9/19 and had not completed Section "C" cognitive patterns and mood because the Coordinator was out sick for the look-back period (7 days) and no other staff member completed the assessment. The assessment was not done. On 7/25/19 at 1 pm an interview was conducted with the Director of Nursing who stated she expected Resident #72 ' s annual MDS dated 4/9/19 to be completed and accurate.	F 636	requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the July 25, 2019 survey and does not constitute an agreement or admission of Clapp's Convalescent Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of August 22, 2019. For the resident affected: Resident #72 had a quarterly assessment completed on July 3, 2019 and section C was completed accurately. In the assessment in which the deficient practice was found on August 15, 2019 the Minimum Data Set Coordinator coded a 1 for item C0100 and the standard "no information" code remained entered in the resident review items. For residents with the potential to be affected: Section C of all Minimum Data Sets of residents who were in the facility as of August 5, 2019 were reviewed by Minimum Data Set Coordinators and Director of Nursing. Audit was complete	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 636	Continued From page 3	F 636	by August 15, 2019 and no areas of concern were found. Measures put in place: Education was also provided to both Minimum Data Set Coordinators on August 6, 2019 by the Director of Nursing related to accurately completing Section C of all Minimum Data Sets and if one MDS coordinator is out of the facility the other MDS coordinator or DON will complete Section C. Section C of the Resident Assessment Instrument manual was reviewed and education provide by the Director of Nursing and Director of Operations. Monitoring: An audit will be conducted on 10 residents per month x 3 quarters who have had a Minimum Data Set completed. The Audit will focus will review Section C of these resident's Minimum Data Set assessments. Should substantial compliance be found after monthly monitoring, the monitoring will then be reduced to 5 residents per quarter x 3 quarter. The Director of Nursing will bring the results of the audits to the Quality Assurance Meeting. This plan of correction and the quality improvement monitoring will be followed by the facility's Quality Assurance Performance Improvement Committee and any areas of concern will be addressed timely and appropriately.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		8/22/19

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 641	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of physical restraints (Resident #25), behaviors (Resident #25), life expectancy (Resident #67), pressure ulcers (Resident #83), discharge status (Resident #89), and active diagnosis (Resident #82) for 5 of 22 sampled residents. The findings included: 1a. Resident #25 was admitted to the facility on 5/21/19 with diagnoses that included hemiplegia (paralysis of one side of the body) and dementia. The admission Minimum Data Set (MDS) assessment dated 5/28/19 indicated Resident #25 ' s cognition was moderately impaired. She required the extensive assistance of 2 or more with bed mobility and was dependent on 2 or more staff for transfers. Resident #25 was coded with a physical restraint (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) used in bed daily. MDS Coordinator #2 coded Resident #25 ' s 5/28/19 MDS in the area of physical restraints. The Care Area Assessment (CAA) related to physical restraints for Resident #25 ' s 5/28/19 MDS indicated she used side rails to the bed to aid in assistance with bed mobility. An observation was conducted of Resident #25	F 641	This plan of correction will serve as the facility's allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the July 25, 2019 survey and does not constitute an agreement or admission of Clapp's Convalescent Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of August 22, 2019. For the residents affected: The Minimum Data Set Coordinators submitted corrected MDS Assessments as of July 25, 2019 for Residents #25, #67, #83, #89, and #82. For the residents with the potential to be affected: The Minimum Data Set Coordinators reviewed the current Minimum Data Set for residents who were in the facility as of August 5, 2019. The following items were checked for accuracy for behaviors, life expectancy, pressure ulcers, discharge status, and active	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 641	Continued From page 5 on 7/22/19 at 4:38 PM. Resident #25 was seated in her wheelchair in her room. Her bed was observed to have quarter length side rails in the down position. An interview was conducted with Nursing Assistant (NA) #1 on 7/22/19 at 4:39 PM. NA #1 reported that Resident #25 used the side rails to help her with bed mobility. She indicated that the rails had not prevented her from getting up nor had they restricted her movement. An interview was conducted with MDS Coordinator #2 on 7/23/19 at 9:54 AM. The physical restraints section of Resident #25 ' s 5/28/19 MDS was reviewed with MDS Coordinator #2. MDS Coordinator #2 revealed this was an error. She stated that Resident #25 ' s side rails were not a physical restraint and this section was coded inaccurately. An interview was conducted with the Director of Nursing (DON) on 7/25/19 at 12:05 PM. She indicated that she expected the MDS to be coded accurately. 1b. Resident #25 was admitted to the facility on 5/21/19 with diagnoses that included dementia. A psychotropic medication documentation note indicated Resident #25 had verbal behaviors that shift, and she refused to eat dinner or a snack. The admission Minimum Data Set (MDS) assessment dated 5/28/19 indicated Resident #25 ' s cognition was moderately impaired. She was coded with no behaviors and no rejection of care. The Social Worker (SW) coded Resident	F 641	diagnosis. This audit will be completed by August 22, 2019. . Should any errors be found, a corrected Minimum Data Set will be corrected and submitted by the facility Minimum Data Set Coordinators. The Minimum Data Set Coordinators were re-educated related to the previously listed areas and the importance of coding accurately by the Director of Nursing and Director of Operations on 8/9/2019. The information for the training was gathered from the Resident Assessment Instrument manual. To ensure substantial compliance with F641 is sustained, the Director of Nursing will audit ten completed assessments monthly for three months to ensure no errors were made in the areas of physical restraints, behaviors, life expectancy, pressure ulcers, discharge status, and active diagnosis. If substantial compliance is found during the monthly audit, the audit will then be reduced to 10 MDS Assessments quarterly for three quarters. If substantial compliance continues to be found, the audit will be discontinued. This citation and the plan of correction will be followed by the facility's Quality Assurance Performance Improvement Committee and results of this audit will be discussed in the monthly meetings and as needed. The Director of Nursing will be responsible for presenting this plan of correction to the QAPI Committee. Any areas of concern will be addressed upon discovery with the committee's appropriate members.	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 641	Continued From page 6	F 641		

#25 ' s 5/28/19 MDS in the area of behaviors.

An interview was conducted with the SW on 7/23/19 at 10:20 AM. The behavior section of Resident #25 ' s 5/28/19 MDS that indicated he had no behaviors and no rejection of care was reviewed with the SW. The psychotropic medication documentation note that indicated Resident #25 had behavioral symptoms on 5/28/19 was reviewed with the SW. The SW revealed that she reviewed nursing notes and medication administration notes to code the behavior section, but she had not reviewed the psychotropic medication documentation notes. She further revealed that this MDS was coded inaccurately in the area of behaviors.

An interview was conducted with the Director of Nursing (DON) on 7/25/19 at 12:05 PM. She indicated that she expected the MDS to be coded accurately.

2. Resident #67 was admitted to the facility on 6/24/19 with diagnoses that included congestive heart failure.

Record review indicated Resident #67 was on hospice services since admission.

The admission Minimum Data Set (MDS) assessment dated 7/1/19 indicated Resident #67 ' s cognition was severely impaired. He was coded with hospice services but was not coded with a life expectancy of less than 6 months. MDS Coordinator #2 coded both the hospice section and the life expectancy section of Resident #67 ' s 7/1/19 MDS.

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 641	Continued From page 7	F 641		

An interview was conducted with MDS Coordinator #2 on 7/23/19 at 9:54 AM. The 7/1/19 MDS for Resident #67 that indicated he had hospice services but had no life expectancy of less than 6 months was reviewed with MDS Coordinator #2. The MDS Coordinator revealed this MDS was coded inaccurately for life expectancy. She stated that she had recently been to an MDS training where she learned that if hospice was coded that life expectancy needed to be coded as well. She reported she had not known this information prior to her training.

An interview was conducted with the Director of Nursing (DON) on 7/25/19 at 12:05 PM. She indicated that she expected the MDS to be coded accurately.

3. Resident #83 was admitted to the facility on 8/15/15 with multiple diagnoses including dementia. The annual Minimum Data Set (MDS) assessment dated 7/8/19 revealed that Resident #83 had moderate cognitive impairment and she had three (3) stage 3 pressure ulcers.

Resident #83 had a doctor's order dated 4/30/19 to clean right heel wound with normal saline, pat dry, skin prep peri wound, place santyl (an ointment that removes dead tissue from the wound) in wound bed, cover with hydrofera blue (an antibacterial wound dressing) and cover with allevyn dressing (an absorbent foam dressing) and change once daily until healed.

Review of the weekly pressure ulcer assessment dated 7/2/19 indicated that Resident #83 had one (1) stage 3 pressure ulcer on the right heel.

On 7/24/19 at 9:26 AM, MDS Nurse #2 was

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 641	Continued From page 8	F 641		

interviewed. The MDS Nurse stated that Resident #83 had one pressure ulcer on her right heel. The MDS Nurse reviewed the annual MDS assessment dated 7/8/19 and stated that it was an error, it should have been coded 1 instead of 3 under stage 3 pressure ulcer.

On 7/25/19 at 12:04 PM, the Director of Nursing (DON) was interviewed. The DON verified that Resident #83 had only 1 stage 3 pressure ulcer and it was on her right heel. She further indicated that she expected the MDS assessments to be coded accurately.

4. Resident #89 was admitted to the facility on 6/5/19 with multiple diagnoses including intracerebral hemorrhage. The admission Minimum Data Set (MDS) assessment dated 6/12/19 indicated that Resident #89 had moderate cognitive impairment. The discharge MDS assessment dated 6/18/19 revealed that Resident #89 was discharged to the acute hospital on 6/18/19.

Resident #89's nurse's notes were reviewed. The note dated 6/18/19 at 6:09 PM revealed that discussion with the resident's family regarding end of life wishes and hospice services was conducted. The family voiced a desire to transfer Resident #89 to the hospice house. The attending physician was notified and gave an order for hospice consult and admit. The hospice Nurse came and spoke with the family and agreement to transfer Resident #89 to hospice house was made. Resident #89 was transferred to the hospice house around 6:15 PM.

On 7/24/19 at 9:26 AM, MDS Nurse #2 was

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 641	Continued From page 9	F 641		

interviewed. The MDS Nurse reviewed the nurse's notes and verified that Resident #89 was transferred to the hospice house instead of the acute hospital. The MDS Nurse reviewed the discharge MDS assessment dated 6/18/19 and stated that it was an error, the discharge status should have been coded hospice house instead of acute hospital.

On 7/25/19 at 12:04 PM, the Director of Nursing (DON) was interviewed. The DON verified that Resident #89 was discharged to the hospice house. She further indicated that she expected the MDS assessments to be coded accurately.

5. Resident #82 was admitted to the facility on 6/29/19 with the diagnoses of depression, anxiety, and non-Alzheimer ' s dementia.

Resident #82 ' s 14-day Minimum Data Set (MDS) dated 7/12/19 revealed entry from acute hospital. The resident had clear speech, understood and understands with a moderate cognitive deficit. Active diagnoses did not include anxiety and depression. Antipsychotic medications received section were coded "antianxiety for 7 days and antidepressant for 7 days."

Resident #82 ' s care plan onset dated 7/10/19 revealed psychotropic medication goal was effective with no side effects and intervention to monitor the resident ' s mood, behavior and cogitative status.

On 7/24/19 at 2:00 pm an interview was conducted with MDS Coordinator #1 who stated that she "missed checking the diagnoses anxiety and depression for Resident #82's 14-day MDS

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 641	Continued From page 10 dated 7/12/19 and it would be corrected." On 7/25/19 at 1:00 pm an interview was conducted with the Director of Nursing who stated she expected Resident #82 ' s 14-day MDS dated 7/12/19 to be completed and accurate.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		8/22/19

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 657	Continued From page 11 Based on record review, observation, and staff interview, the facility failed to revise care plans related to wanderguards for 2 of 3 sampled residents (Residents #6 and #19). The findings included: 1. Resident #19 was admitted to the facility on 8/11/17 with diagnoses that included Alzheimer' s disease and dementia with behavioral disturbance. A physician ' s order dated 6/5/18 indicated a wanderguard (an electronic alert system that alarmed and locked the facility exit doors when cognitively impaired residents with wandering behaviors attempted to exit the building) was initiated for Resident #19. The annual Minimum Data Set (MDS) assessment dated 5/15/19 indicated Resident #19 ' s cognition was severely impaired. She was noted to wander daily and a wander/elopement alarm was used daily. Resident #19 ' s care plan included the problem/need of the risk for increased behaviors due to wandering. This problem /need was initiated on 5/15/19 and included, in part, the intervention of monitoring the skin breakdown around the wanderguard and checking circulation. An observation was conducted on 7/22/19 at 12:30 PM of Resident #19. Resident #19 was self-propelling her wheelchair in a common area of her unit. Her wanderguard was attached to her wheelchair. Resident #19 had no wanderguard in	F 657	This plan of correction will serve as the facility's allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the July 25, 2019 survey and does not constitute an agreement or admission of Clapp's Convalescent Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of August 22, 2019. For the residents affected: On July 25, 2019, Residents #6 and #19 care plans were updated by the Minimum Data Set Coordinator to reflect resident's #6 and #19 location of their secure care bracelets. For the residents with the potential to be affected: All other residents who currently have secure care bracelets were reviewed by Minimum Data Set Coordinators of Director of Nursing on August 7, 2019 to ensure proper placement of the secure care bracelets has been care planned. There were no other residents found to	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 657	Continued From page 12 place to her ankle or wrist. An observation was conducted on 7/24/19 at 11:45 AM of Resident #19. Resident #19 was self-propelling her wheelchair in the hallway of the facility that led to the main entrance/exit door. Her wanderguard was attached to her wheelchair. Resident #19 had no wanderguard in place to her ankle or wrist. An interview was conducted with Nurse #3 on 7/24/19 at 2:00 PM. She stated Resident #19 had a wanderguard and that it was in place on her wheelchair. Nurse #3 reported that Resident #19 had previously taken off her own wanderguard when it was on her ankle which was why it was on her wheelchair. She indicated that she was unable to recall when the wanderguard was initially placed on her wheelchair, but she thought it was at least 6 months ago. During an interview with the Director of Nursing (DON) on 7/25/19 at 8:47 AM she reported that she was unsure how long Resident #19 had her wanderguard on the wheelchair, but she indicated it had been several months at minimum. In an interview on 7/25/19 at 11:53 AM, the Minimum Data Set (MDS) Coordinator #2 stated she was not aware that Resident #19's wanderguard was not on her ankle or wrist but rather on her wheelchair. She stated the care plan should have been revised when the wanderguard was moved to the wheelchair. In a follow up interview on 7/25/19 at 11:53 AM, the DON stated it was her expectation that Resident #19's care plan was revised to reflect the wanderguard placement to her wheelchair	F 657	have error in their care plans related to were the secure care are placed on the resident. Measures put in place: Both of the Minimum Data Set Coordinators were educated on August 8, 2019 by the Director of Nursing and Director of Operations on the revision of care plans related to the placement of secure care bracelet on the residents. Monitoring: To ensure on-going compliance, the care plans of five residents with secure care bracelets will be reviewed on time per month x 3 months to verify the proper care planning related to where the secure care bracelet is placed on the resident has been care planned with appropriate interventions and goals in place. This quality improvement monitoring will be completed by the Director of Nursing or Unit Manager. Should substantial compliance be found, the monitoring will be reduced to five residents per quarter x 3 quarters. If substantial compliance is found, this quality improvement monitoring will be discontinued. This plan of correction and the quality improvement monitoring will presented to the Quality Assurance committee by the Director of Nursing. The results of the audits will be followed by the facility's Quality Assurance Performance Improvement Committee and any areas of concern will be addressed timely and appropriately.	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 657	Continued From page 13	F 657		

rather than her person.
2. Resident #6 was admitted on 11/5/03 with a diagnosis of Dementia.

Review of Resident #6's July 2019 Physician orders included an order for staff to check the wander guard every shift. The order was dated 4/20/18.

Resident #6's annual Minimum Data Set dated 7/17/19 indicated he was cognitively intact and exhibited wandering behaviors. Resident #6's behavioral Care Area Assessment indicated he propelled around the facility in his wheelchair and had a wander guard in place.

Resident #6's care plan last revised on 7/17/19 read he was at risk for injury related to wandering. Interventions included monitoring the skin for breakdown around the wander guard bracelet and checking circulation.

In an observation on 7/24/19 at 9:40 AM, Resident #6 was observed propelling his wheelchair into the dining room. His wander guard was observed attached to the left armrest of his wheelchair.

In an observation on 7/25/19 at 9:45 AM, Resident #6 was sitting in his wheelchair inside the staff lounge. His wander guard was attached to the left armrest of his wheelchair.

In another observation on 7/25/19 at 10:00 AM, Resident #6 was in his room sitting in his wheelchair. His wander guard was attached to the left armrest of his wheelchair. He was noted to have bilateral lower extremity edema. He was pleasant and stated he got a pack of crackers

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 657	Continued From page 14 from the lounge. In an interview on 7/25/19 at 10:35 AM, the Director of Nursing (DON) stated his wander guard was moved from his lower extremity due to edema. In an interview on 7/25/19 at 11:53 AM, the Minimum Data Set (MDS) Coordinator #2 stated she was not aware that Resident #6's wander guard was not on him but rather his wheelchair. She stated the care plan should have been revised on 7/17/19 to reflect that his wander guard was to be placed on his wheelchair due to edema. In an interview on 7/25/19 at 11:53 AM, the DON stated it was her expectation that Resident #6's care plan was revised to reflect the wander guard placement to his wheelchair rather than his person due to edema.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to provide a safe transfer with a mechanical lift for a dependent resident (Resident #25) to prevent the resident ' s	F 689	This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities.	8/22/19

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 689	Continued From page 15 toe from hitting the lift bar causing the resident to lose her toe nail for 1 of 9 residents sampled for accidents. The findings included: Resident #25 was admitted to the facility on 5/21/19 with diagnoses that included hemiplegia (paralysis of one side of the body) affecting the left dominant side and dementia. The admission Minimum Data Set (MDS) assessment dated 5/28/19 indicated Resident #25 ' s cognition was moderately impaired. She was assessed with no behaviors and no rejection of care. Resident #25 was dependent on 2 or more staff for transfers and she had functional limitations with range of motion in both sides of her lower extremities. Resident #25 ' s care plan included the problem/need of the risk for unmet needs related to extensive to total staff assistance for all Activities of Daily Living (ADLs). This problem/need was initiated on 5/28/19 and included the intervention of transfers via a mechanical lift. An incident report dated 7/13/19 completed by Nurse #2 indicated Nursing Assistant (NA) #2 reported to her that she and another NA (NA #1) were transferring Resident #25 using the mechanical lift when the resident ' s left foot hit a bar on the mechanical lift resulting in her toenail of the 2nd digit to come off. Nurse #2 indicated that Resident #25 ' s toe was bleeding, and she cleaned the injury and applied a dressing. Resident #25 stated "what happened" and when she was informed her toenail came off she	F 689	Preparation and submission of this plan of correction is in response to DHHS 2567 for the July 25, 2019 survey and does not constitute an agreement or admission of Clapp□s Convalescent Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it□s allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of August 22, 2019. For the resident affected: On July 13, 2019, Certified Nursing Assistants were immediately reeducated on monitoring the resident's position of her feet while transferring the resident with the total lift by the hall nurse on duty at the time. For residents with the potential to be affected: Education will be provided by August 22, 2019 to Nurses and Certified Nursing Assistants by the Director of Nursing. The Director of Nursing and Director of Operations utilized the manufacturer's manual for the training for the total lift. The areas in-serviced on were how to properly lift a patient, attaching slings to the lift, lifting/moving the patient, and transferring the patient to a commode, bathing unit, and wheelchair.	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 689	Continued From page 16 stated, "I didn ' t even feel it". The physician are Responsible Party (RP) were notified of the incident. The immediate post incident action was noted to be NA re-education regarding monitoring resident ' s position while using the mechanical lift. On 7/13/19 Resident #25 ' s care plan related to the risk for impaired skin integrity was updated with the intervention of staff education on guarding extremities during mechanical lift transfers related to Resident #25 ' s toe nail falling off during a transfer. On 7/15/19 Resident #25 ' s care plan related to the risk for skin integrity was updated with the intervention of a podiatry referral with an appointment scheduled on 7/24/19. An observation was conducted of Resident #25 on 7/22/19 at 10:00 AM. Resident #25 was seated in her wheelchair in a common area of the facility. An interview was attempted, but she was unable to answer any open-ended questions. A phone interview was conducted with Nurse #2 on 7/23/19 at 11:48 AM. She confirmed that on 7/13/19 NA #2 came to her after she and NA #1 assisted Resident #25 out of bed using the mechanical lift. Nurse #2 reported that NA #1 and NA #2 told her Resident #25 ' s left foot hit a bar on the mechanical lift causing her toenail to come off. She stated that the toe was bleeding so she cleaned the injury and applied a dressing. She indicated that Resident #25 reported no pain from the injury. She reported that Resident #25 required no further medical treatment related to the injury, she had no bruising identified, and no residual pain following the injury. Nurse #2 stated	F 689	Measures put in place: Any incident that occurs while using a total lift will be investigated by a Unit Manager, Director of Nursing, or Director of Operations. It will be determined if the staff used the lift properly, and if it was a safe transfer. Depending on results of the investigation clinical team will respond timely and appropriately. Monitoring: Director of nursing, a Unit manager, or Director of operations will observe 10 resident transfers with the total lift a week for four weeks. If substantial compliance is found, this quality improvement monitoring will be discontinued. This plan of correction and the quality improvement monitoring will be followed by the facility's Quality Assurance Performance Improvement Committee and any areas of concern will be addressed timely and appropriately. The Director of Nursing will be responsible for presenting this Plan of Correction to the Quality Assurance Performance Improvement committee.	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 689	Continued From page 17	F 689		

that after the incident she re-educated NA #1 and NA #2 on the need to monitor where the resident ' s arms and legs were at throughout the use of the mechanical lift. She indicated she felt the injury was preventable if proper transfer technique of monitoring the resident ' s extremities throughout the transfer had been used. Nurse #2 reported that no other staff were re-educated on mechanical lift technique after this incident.

A phone interview was conducted with NA #1 on 7/23/19 at 12:05 PM. She stated that on 7/13/19 she and NA #2 were transferring Resident #25 from her bed to wheelchair using the mechanical lift. She stated that during the transfer Resident #25 ' s left foot had hit one of the bars on the mechanical lift and her toenail fell off. She indicated that Resident #25 ' s toe was bleeding but that the resident reported no pain. NA #1 stated that Nurse #2 re-educated her and NA #2 after the incident on monitoring where the resident ' s arms and legs were at throughout the use of the mechanical lift. She explained that she and NA #2 had not been paying close enough attention to Resident #25 ' s lower extremities and had not realized the resident ' s left foot hit the bar on the mechanical lift until they noticed the bleeding from her left toe. NA #1 revealed she thought the incident could have been prevented by monitoring Resident #25 ' s limbs throughout the transfer.

An interview was conducted with NA #2 on 7/23/19 at 3:30 PM. NA #2 confirmed NA #1 ' s statement that on 7/13/19 she and NA #1 were transferring Resident #25 from her bed to wheelchair using the mechanical lift and that during the transfer the resident ' s left foot had hit one of the bars on the mechanical lift causing her

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 689	Continued From page 18	F 689		

toenail to fall off. NA #2 stated that they had not noticed the injury until they saw blood on Resident #25 ' s left foot. She indicated that she got Nurse #2 to assess Resident #25 and that the resident said she had no pain from the injury. NA #2 stated that Nurse #2 re-educated her and NA #1 after the incident on monitoring where the resident ' s arms and legs were at throughout the use of the mechanical lift. She verified NA #1 ' s interview that that she and NA #1 had not been paying close enough attention to Resident #25 ' s lower extremities and had not realized the resident ' s left foot hit the bar on the mechanical lift until they noticed the bleeding from her left toe. NA #2 revealed she thought the incident could have been prevented by monitoring Resident #25 ' s limbs throughout the transfer.

An interview was conducted with the Director of Nursing (DON) on 7/23/19 at 4:15 PM. The 7/13/19 incident report for Resident #25 in which she sustained a minor injury to her left foot during a transfer with a mechanical lift was reviewed with the DON. The DON stated that she expected residents to be transferred safely. She reported that after this incident NA #1 and NA #2 were re-educated by Nurse #2 on proper transfer technique with the mechanical lift. She indicated that proper transfer technique included monitoring the resident ' s extremities throughout the transfer. She reported that no other staff were included in this re-education. The DON stated that Resident #25 was also referred to podiatry with an appointment scheduled for 7/24/19. She explained that there were no after effects of the injury such as bruising or pain, but that they had wanted the podiatrist to assess the resident to ensure no further care or preventative treatments were required for Resident #25.

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 732		8/22/19

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 732	Continued From page 20	F 732		

by:
Based on record review and staff interviews, the facility failed to ensure the Posted Staffing and Census sheets reflected an accurate total number and total care hours worked for Registered Nurses (RNs) on 25 of 30 days reviewed.

The findings included:

A review of the facility ' s posted staffing and census sheets was conducted on 7/23/19 for the dates of June 22 through July 21, 2019. There were a total of 25 of 30 days (6/22, 6/23, 6/25-6/30, 7/2-7/7, 7/9-7/11, 7/13-7/15, and 7/17-7/21) that indicated 0 Registered Nurses (RNs) worked on all 3 shifts and 0 total care hours were worked by RNs on all 3 shifts. A review of the daily assignment sheets and staff time sheet hours was conducted from June 22 through July 21, 2019 and was compared to the posted staffing and census sheets and revealed the 25 days that indicated 0 total RNs and 0 RN care hours worked were inaccurate. An RN had worked on all 25 days for a minimum of 8 hours as required.

An interview was conducted with the Director of Operations (DOO) on 7/23/19 at 10:50 AM. The posted staffing and census sheets for the 25 days that were found to be inaccurate in the area of total number and total care hours worked for RNs were reviewed with the DOO. He confirmed that the posted staffing and census sheets for these 25 days were inaccurate in the area of total number and total care hours worked for RNs. The DOO stated that Medical Records staff completed the posted staffing and census sheets and she had only accounted for nurses who were

This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the July 25, 2019 survey and does not constitute an agreement or admission of Clapp□s Convalescent Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it□s allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of August 22, 2019.

For the Residents affected, the staffing coordinator responsible for maintaining staffing sheets was in-serviced on August 9, 2019 by the Director of Operations related to making sure the facility name, date, total number of actual hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift, and resident census are all accurate on the posted staffing sheet.
Monitoring: The Director of Nurses or Director of Operations will review the daily staffing sheet 5 days a week for four

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 732	Continued From page 21 assigned on the floor and failed to include the RN Unit Managers (UMs). He reported that there were two RN UMs who worked Monday through Friday and they rotated on the weekends to ensure an RN was working a minimum of 8 hours per day as required. The DOO indicated he expected the posted staffing and census sheets to be accurate. An interview was conducted with Medical Records staff on 7/23/19 at 10:58 AM. She stated that she had spoken with the DOO and she confirmed his statement that she had only accounted for nurses who were assigned on the floor and she failed to include the RN UMs on the posted staffing and census sheets.	F 732	weeks then will review 15 daily staff postings monthly for two months to ensure the staffing sheets have the accurate staffing information documented on the staffing sheets. If no areas of concern are found, the monitoring will be reduced to once per month until next annual recertification survey. This plan of correction and the quality improvement monitoring will be followed by the facility's Quality Assurance Performance Improvement Committee and any areas of concern will be addressed timely and appropriately by committee members. The Director of Nursing will be responsible for presenting this Plan of Correction to the Quality Assurance Performance Improvement committee.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		8/22/19

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 756	Continued From page 22 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff, resident, Physician and Pharmacist interviews and record review, the Consultant Pharmacist failed to identify and address the facility's failure to monitor targeted behavior and mood symptoms for the use of an antidepressant medication. This was for 1 (Resident #37) of 5 residents reviewed for unnecessary medications. The findings included: Resident #37 was admitted on 2/4/17 with a diagnosis of Depression. Resident #37's July 2019 Physician orders included an order for Remeron (antidepressant) 15 milligrams (mg) by mouth daily at bedtime. The date of the original order for Remeron read	F 756	This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the July 25, 2019 survey and does not constitute an agreement or admission of Clapp□s Convalescent Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 756	Continued From page 23 3/20/17. Review of a Consultant Pharmacist Recommendation dated 10/10/18 read Resident #37 had been receiving Remeron since March 2017. There was no recommendation regarding the monitoring of mood or target behaviors. Review of a Consultant Pharmacist Recommendation dated 5/2/19 read Resident #37 had been receiving Remeron since March 2017. There was no recommendation regarding the monitoring of mood or target behaviors. Resident #37's quarterly Minimum Data Set dated 6/4/19 indicated she was cognitively intact and exhibited no behaviors. Her mood was coded as feeling tired and problems concentrating. Resident #37 was coded as receiving an antidepressant 7 of 7 days of the look back period. Resident #37 care plan last revised on 6/4/19 read she was at risk for adverse effects due to the use of an antidepressant medication. Interventions included monitoring of mood, behaviors and cognitive status. In an interview on 7/24/19 at 9:40 AM, Resident #37 reported she was not feeling down or sad but reported a lack of energy. She appeared alert and pleasant. In an interview on 7/24/19 at 10:04 AM, the Physician stated it was his expectation that the Consultant Pharmacist identify any missing mood and behaviors monitoring for Resident #37 and notify the facility, so monitoring could be implemented.	F 756	deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it□s allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of August 22, 2019. For the resident found to be affected: On August 9, 2019 an assessment was completed on Resident #37 to identify the target behavior of her antidepressant. Resident #37 was assessed by the Director of Nursing and Minimum Data Set Coordinator who consulted with the attending physician. The targeted behavior that was identified was thoughts of hopelessness and mood instability per Resident #37. To ensure other residents are not affected: Nurses will be in-serviced by august 22, 2019 by Director of Nursing and Director of Operations regarding what a target behavior is and our new process to ensure all residents who are on antidepressant medications have a target behavior that is being monitored. All resident's who are taking an antidepressant will be audited by August 19, 2019 to ensure all resident have a target behavior identified and an assessment is being completed. All new physician orders will be reviewed 5 days a week by the unit manager, Director of Nursing, or Minimum Data Set Coordinators to monitor any new orders for antidepressants. The staff listed above	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 756	Continued From page 24 In a telephone interview on 7/24/19 at 2:30 PM, the Consultant Pharmacist stated it was her expectation that the facility monitored specific behaviors and mood for Resident #37. She stated she was unsure if she addressed with the facility the lack of behavior and mood monitoring for the use of Resident #37's Remeron. The Consultant Pharmacist stated she started at the facility in September 2018 and it could have been an oversight. In an interview on 7/25/19 at 8:30 AM, Nurse #3 stated Resident #37 lost a grandchild over a year ago and a roommate she was very close too died last year. Nurse #3 stated Resident #37 has not exhibited any evidence of sadness or crying. She stated Resident #37 participated in activities and has lots of visitors. In an interview on 7/25/19 at 11:53 AM, the Director of Nursing (DON) stated it was her expectation that the Consultant Pharmacist identify and address the facility's lack of mood and behaviors monitoring for the use of Remeron.	F 756	will ensure a target behavior has been identified and ensure a target behavior assessment is completed ongoing. The consultant Pharmacist was educated on August 9, 2019 by the Director of Operations. Ongoing the pharmacist will review all residents who are on antidepressants and make sure each resident has a target behavior identified. If not, the pharmacist will report to the Director of Nursing or Unit manager while the pharmacist is the facility. To ensure on-going compliance: All new physician orders will be reviewed 5 days a week by the unit manager, Director of Nursing, or Minimum Data Set Coordinators to monitor any new orders for antidepressants. The staff list previously will ensure a target behavior has been identified and ensure a target behavior assessment is completed ongoing. Also, the pharmacist will review all residents who are on antidepressants monthly and make sure each resident has a target behavior identified. If a target behavior is not identified, the pharmacist will report to the Director of Nursing or Unit manager while the pharmacist is the facility. Monitoring: Monthly for three months the Director of Nursing or Unit Manager will audit ten residents who on prescribed antidepressants and ensure they have target behaviors identified and weekly assessments are being completed monthly for three months to ensure residents are free from unnecessary medications This citation and the plan of correction will	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 756	Continued From page 25	F 756	be followed in the facility's Quality Assurance Performance Improvement Committee and results of this audit will be discussed in the monthly meetings and as needed. The Director of Nursing will be responsible for presenting this Plan of Correction to the QAPI Committee. Any areas of concern will be addressed immediately with the committee's appropriate members.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		8/22/19

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 758	Continued From page 26 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and Physician and staff interview, the facility failed to try non pharmacological interventions prior to administering as needed (PRN) psychotropic medication and failed to have a specific behavior to indicate the use of the PRN psychotropic medication (Resident #77) and also failed to attempt a gradual dose reduction (GDR) as required for psychotropic medication (Resident #37) for 2 of 5 sampled residents reviewed for unnecessary medications. Findings included: 1. Resident #77 was admitted to the facility on 8/7/17 with multiple diagnoses including dementia	F 758	This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the July 25, 2019 survey and does not constitute an agreement or admission of Clapp□s Convalescent Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 758	Continued From page 27	F 758		

and Alzheimer's disease. The annual Minimum Data Set (MDS) assessment dated 7/3/19 indicated that Resident #77 had severe cognitive impairment and she had received an antianxiety medication for 6 days during the assessment period.

Resident #77's care plan dated 7/3/19 included a problem of at risk for agitation and anxiety related to dementia and Alzheimer's disease. The goal was "I will not have increased agitation and anxiety".
The approaches included to provide diversional activities when behaviors became disruptive.

Resident #77's doctor's orders included Xanax (antianxiety medication) 0.25 milligrams (mgs) by mouth daily for anxiety.

Resident #77 doctor's orders were reviewed. On 3/19/19, there was an order to give Ativan 1 milligrams (mgs) intramuscular (IM) x (times) 1 dose now for anxiety/agitation, on 6/26/19 with 2 orders, (1)an order to give Ativan 1 mgs IM x 1 dose now agitation/anxiety and (2) to give Ativan 1 mgs IM now (no indication for use) and on 6/30/19, to give Ativan 1 mgs IM x 1 dose now (no indication for use).

Nurse #4 was the nurse who received the order for the PRN Ativan and who administered the Ativan on 6/26/19 at 4 PM and 10 PM and on 6/30/19 at 5:00 PM.

Resident #77's Medication Administration Records (MARs) and the nurse's notes were reviewed. The March 2019 MAR revealed that Resident #77 had received Ativan 1 mgs IM on 3//19/19 at 11:04 AM. The nurse's notes were

deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as its allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of August 22, 2019.

For the resident affected: On August 7, 2019 an in-service was held for Nurses and Certified Nursing Assistants to educate them on gradual dose reductions and documenting non-pharmacological interventions. On July 24, 2019 resident #37's Remeron was reduced to 7.5mg at bedtime. The physician wanted to wait 30 days prior to attempting a gradual dose reduction for the Ativan. Physician documented professional rationale for waiting to reduce the Ativan. At 30 days the Physician will assess the resident regarding the gradual dose reduction of the Ativan.
For the residents with the potential to be affected: An in-service was held August 7, 2019 by Director of Nurses and Director of Operations for nurses and CNAs to review the facilities practice of using non-pharmacological interventions prior to administering or receiving a new order to administer an as needed medication. These are to be documented in the resident medical record. The DON and DOO gave examples of interventions which Nurses and CNAs can use prior to using medication. The in-service also addressed what a gradual dose reduction is and how the pharmacy plays a role in

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 758	Continued From page 28 reviewed and there was no entry for 3/19/19 of any nonpharmacological approaches that were tried prior to administering the PRN Ativan IM and there was no entry of any specific behavior to indicate the use of the PRN Ativan. The April 2019 MAR revealed that Resident #77 had received Ativan 1 mgs IM on 4/3/19 at 10:00 PM. Review of the doctor's orders revealed that there was no order dated 4/3/19 for the Ativan 1 mgs. The nurse's notes were reviewed and there was no entry for 4/3/19 of any nonpharmacological approaches that were tried prior to administering the PRN Ativan IM and there was no entry of any specific behavior to indicate the use of the PRN Ativan. The June 2019 MAR revealed that Resident # 77 had received Ativan 1 mgs IM on 6/26/19 at 4:00 PM and at 10:00 PM and on 6/30/19 at 5:00 PM. The nurse's notes were reviewed and there was no entry for 6/26/19 and 6/30/19 of any nonpharmacological approaches that were tried prior to administering the PRN Ativan IM and there was no entry of any specific behavior to indicate the use of the PRN Ativan. On 7/24/19 at 10:18 AM, the Physician was interviewed. The Physician stated that IM Ativan was used for Resident #77 for quicker action. He indicated that Resident #77 had exhibited major behavioral issues. He reported that he expected the nursing staff to try diversional activities or redirections prior to administering any PRN psychotropic medications. The Physician also indicated that he expected the nursing staff to document the specific behavior exhibited by the resident and the approaches that were tried prior to administering the PRN psychotropic	F 758	identifying residents who need a gradual dose reduction of a psychotropic medication. The nurses will now be required to document in the resident's chart during the time of the gradual dose reduction if the gradual dose reduction is effective or not effective for the resident. Any Nurse or CNA who was unable to attend in-service will be educated on the above information prior to August 22, 2019. All licensed nurses will also be re-educated by August 22, 2019 related to identifying and documenting the behavior which is requiring the PRN Ativan or other related PRN medications to be given. All residents who are actively on a psychotropic medication will have their chart reviewed by the Director of Nursing, Unit Manager, Minimum Data Set Coordinator, or Pharmacist prior to August 19, 2019. This will ensure all residents who are taking a psychoactive medication, have had or the physician has written documentation why a resident should have or not have a gradual dose reduction. Monitoring: Monthly for three months the Director of Nursing or Unit Manager will audit ten residents who are prescribed psychotropic medication and ensure they have had a gradual dose reduction or documentation stating why a gradual dose reduction is not warranted from the resident's physician. Weekly for 8 weeks, 5 days a week the Director of Nursing, Minimum Data Set Coordinators, or Unit Manager will review all new orders for as needed psychotropic orders. They will then review the resident's chart to ensure	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 758	Continued From page 29 medication. On 7/24/19 at 3:24 PM, Nurse #4 was interviewed. She stated that when Resident #77 was exhibiting behaviors, she would redirect the resident by playing music, showing pictures or other activities and these normally would calm the resident down. The Nurse indicated that she would document these approaches in the nurse's notes. Nurse #4 also stated that when a PRN psychotropic medication was ordered, she would document the specific behavior exhibited by the resident in the nurse's notes. Nurse #4 reviewed the nurse's notes and she stated that she could not find any documentation of any diversional activities or specific behavior to indicate the use of the PRN Ativan on 6/26/19 and 6/30/19. On 7/24/19 at 3:55 PM, the Director of Nursing (DON) was interviewed. The DON stated that when a resident was agitated/combative, she expected the nurse to try to find the cause of the agitation/combativeness and to try to intervene prior to calling the doctor for PRN psychotropic medication and to document the interventions that were tried in the nurse's notes. The DON also indicated that her expectation was for the nurses to write on the order and in the nurse's notes the indication for the use of the PRN psychotropic medication. The DON further reported that she had reviewed the nursing notes and she did not find any documentation of any diversional activities tried and any specific behavior to indicate the use of the PRN Ativan on 3/9/19, 4/3/19, 6/26/19 and 6/30/19. On 7/5/19 at 1:30 PM, the Nurse Unit Manager #2 stated that she could not find any doctor's order for the PRN Ativan that was administered on	F 758	proper non-pharmacological interventions were used prior to administration and that the Licensed nurse identified and documented the behavior that warranted the medication to be administered. This citation and the plan of correction will be followed by the facility's Quality Assurance Performance Improvement Committee and results of this audit will be discussed in the bi-weekly/monthly meetings and as needed. The Director of Nursing will be responsible for presenting this plan of correction to the QAPI Committee. Any areas of concern will be addressed upon discovery with the committee's appropriate members.	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 758	Continued From page 30	F 758		

4/3/19.

2. Resident #37 was admitted on 2/4/17 with a diagnosis of Depression and Anxiety.

Resident #37's July 2019 Physician orders included an order for Remeron (antidepressant) 15 milligrams (mg) by mouth daily at bedtime. The date of the original order for Remeron read 3/20/17. The July 2019 Physician orders also included an order for Ativan (antianxiety) 0.25mg by mouth at bedtime. The date of the original order for Ativan read 10/9/17.

Review of a Consultant Pharmacist Recommendation dated 10/10/18 read Resident #37 had been receiving Remeron 15 mg at bedtime since March 2017 and Ativan 0.25 mg at bedtime since October 2017. The recommendation was marked by the Physician as he disagreed with an attempted gradual dose reduction (GDR) and dated 11/15/18. There was no additional documentation noted.

Review of a Consultant Pharmacist Recommendation dated 5/2/19 read Resident #37 had been receiving Remeron 15 mg at bedtime since March 2017 and Ativan 0.25 mg at bedtime since October 2017. The recommendation was marked by the Physician as he disagreed with an attempted GDR and dated 5/8/19. There was also a handwritten note that read: Stable on current medication.

Resident #37's quarterly Minimum Data Set dated 6/4/19 indicated she was cognitively intact and exhibited no behaviors. Her mood was coded as feeling tired and problems concentrating.

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 758	Continued From page 31	F 758		

Resident #37 was coded as receiving an antidepressant and antianxiety 7 of 7 days of the look back period.

Resident #37 care plan last revised on 6/4/19 read she was at risk for adverse effects due to the use of an antidepressant and antianxiety medication. Interventions included monitoring of mood, behaviors and cognitive status. Other interventions included psychoactive drug documentation and medications as ordered by the Physician.

In an interview on 7/24/19 at 9:40 AM, Resident #37 reported she was not feeling down or sad but reported a lack of energy. She appeared alert and pleasant.

In an interview on 7/24/19 at 10:04 AM, the Physician stated Resident #37 had several roommates last year and lost a relative about a year ago. He stated he ordered a GDR of her Remeron on 7/24/19 but would not be ordering a GDR of her Ativan. The Physician stated a GDR of Resident #37's Ativan could potentially cause withdrawal since she had taken Ativan for over 40 years. He confirmed he did not document in Resident #37's medical record the rationale for declining a GDR of Remeron and Ativan on 10/10/18 and on 5/2/19.

In a telephone interview on 7/24/19 at 2:30 PM, the Consultant Pharmacist stated she started at the facility in September 2018 and had spoken to the Physician about the need for additional documentation regarding his repeat declining of attempted GDR or Resident #37's Remeron and Ativan.

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 758	Continued From page 32 In an interview on 7/25/19 at 8:30 AM, Nurse #3 stated Resident #37 lost a grandchild over a year ago and a roommate she was very close too died last year. Nurse #3 stated Resident #37 has not exhibited any sadness or crying. She stated Resident #37 participated in activities and has lots of visitors. In an interview on 7/25/19 at 11:53 AM, the Director of Nursing (DON) stated it was her expectation that there be an attempted GDR of Resident #37's Remeron and Ativan unless it was contraindicated. She stated if a GDR was declined, it was her expectation that the Physician document the rationale in the medical record.	F 758		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and resident and staff interviews, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification/complaint survey of 5/24/18. This was for 1 deficiency originally cited 5/24/18 and was subsequently recited on the current recertification survey of 7/25/19. The recited deficiency was in the area of Minimum Data Set accuracy for diagnosis. The continued failure of the facility during two federal	F 867	This plan of correction will serve as the facility□s allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the July 25, 2019 survey and does not constitute an agreement or admission of Clapp□s Convalescent Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of	8/22/19

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 867	Continued From page 33 surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: The tag is cross referenced to: 1. F-641 Based on record review, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of physical restraints (Resident #25), behaviors (Resident #25), life expectancy (Resident #67), pressure ulcers (Resident #83), discharge status (Resident #89), and active diagnosis (Resident #82) for 5 of 22 sampled residents. During the recertification survey of 5/24/18 the facility was also cited at F641 for failing to code the MDS assessment accurately in the area of active diagnosis. On 7/25/19 at 11:40 am an interview was conducted with the Director of Operations who stated the root cause for the repeat tag was human error.	F 867	correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it□s allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of August 22, 2019. The Administrator held a Quality Assurance Performance Improvement meeting on July 29, 2019 with the committee members which included the Director of Nursing, Social Services, Dietary Manager, Minimum Data Set Coordinators, Nurse Supervisors, Medical Director, and Activities Director focusing on the citation of Develop/Implement Comprehensive Care Plan. The facility Quality Assurance Performance Improvement Committee reviewed the new plan of correction for maintaining compliance in this area. During the Quality Assurance Performance Improvement on July 29, 2019 the Administrator re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of any identified deficiency to assure compliance and quality are maintained. The Quality Assurance Performance Improvement Committee will continue to meet on at least a monthly basis	

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 _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	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 867	Continued From page 34	F 867	identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The Facility's Chief Executive Officer will attend the Quality Assurance Performance Improvement meeting for 3 months for validation of on-going quality improvement monitoring to remain in substantial compliance. Opportunities will be corrected as identified by the Director of Operations. The results of these reviews will be submitted to the Quality Assurance Performance Committee by the Administrator for review by Interdisciplinary members each month. The Quality Assurance Performance Committee will evaluate the effectiveness and amend as needed.	