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 10/02/2024

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 and complaint investigation survey was conducted on 09/30/24 through 10/02/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #OO3311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/30/34 through 10/02/24. Event ID# OO3311. The following intakes were investigated NC00220314 and NC00214770. 1 of the 2 complaint allegations resulted in deficiency.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews, the facility failed to protect the residents' right to be free from misappropriation of narcotic medications (oxycodone and hydromorphone) prescribed to treat pain for 6 of 6 residents (Residents #66, 282, 284, 281 and #280) reviewed for misappropriation of property. The findings included:	F 602	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/29/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 10/02/2024

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 602	Continued From page 1	F 602		

1a. Resident #66 was admitted on 04/09/24 with diagnoses that included fracture of the right hip. Resident #66's physician orders included an order dated 04/09/24 for oxycodone 5 milligrams (mg) one tablet by mouth every 6 hours as needed (PRN) for pain.

Resident #66's Medication Administration Record (MAR) revealed that between 07/17/24 to 07/28/24, the PRN oxycodone was documented as administered 4 times by Nurse #1. The dates of administration were: 07/22/24, 07/24/24, 07/27/24 and 07/28/24.
The pharmacy-controlled drug record sheet for Resident #66 revealed that PRN oxycodone was signed out 9 times by Nurse #1 between 07/17/24 to 07/28/24. The dates signed out were once on 07/22/24, twice on 07/23/24, three times on 07/27/24, and three times on 07/28/24.

Review of quarterly Minimum Data Set (MDS) dated 07/17/24 revealed that Resident # 66's cognition was moderately impaired.
During the interview of Resident #66 on 10/01/24 at 04:42 PM the resident denied she asked for pain medications from Nurse #1 and did not receive pain medications. Resident #66 denied having pain.

1b. Resident #283 was admitted to facility on 05/24/24 with diagnoses that included pain disorder and pain in right toe.
Resident #283's physician's orders included an order dated 07/15/24 for oxycodone 5 mg by mouth, 1 tablet every 6 hours PRN for pain.
The medical record indicated Resident #283 resided in the facility 7/17/24 through 7/28/24.

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 10/02/2024

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 602	Continued From page 2	F 602		

Resident #283's MAR revealed that between 07/17/24 to 07/28/24 Nurse #1 documented administration of the PRN oxycodone two times. The dates of administration were 07/22/24 and 07/24/24.

Resident #283's pharmacy-controlled drug record sheet revealed that PRN oxycodone was signed out 12 times by Nurse #1 between 07/17/24 to 07/28/24. The dates signed out were twice on 07/22/24, once on 07/23/24, three times on 07/24/24, three times on 07/27/24, and three times on 07/28/24.

1c. Resident #282 was admitted to the facility on 07/23/24 with diagnoses that included fracture of the neck of the right femur.
Resident #282's physician's orders included an order dated 07/23/24 for hydromorphone 2 mg by mouth every 4 hours PRN for pain.
The medical record indicated that the resident resided in the facility from 07/23/24 to 07/28/24.

Resident #282's MAR revealed that between 07/23/24 to 07/28/24, hydromorphone was documented as administered once by Nurse #1 on 07/27/24.

The pharmacy-controlled drug record sheet for Resident #282 revealed that hydromorphone was signed out 9 times by Nurse #1 between 07/23/24 to 07/28/24. The dates signed out were: one time on 07/24/24, four times on 07/27/24, and four times on 07/28/24.
1d. Resident #284 was admitted to the facility on 07/09/24 with diagnoses that include pain in right knee and right foot.

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 10/02/2024

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 602	Continued From page 3 Resident #284's physician's orders included an order dated 07/09/24 for oxycodone 5 mg by mouth, 1 tablet by mouth every 4 hours PRN for moderate to severe pain. The medical record indicated Resident #284 resided in the facility 7/17/24 through 7/28/24. Resident #284's MAR revealed that between 07/17/24 to 07/28/24, oxycodone 5 mg was documented as administered one time by Nurse #1 on 07/27/24. The pharmacy-controlled record for Resident #284 revealed that oxycodone was signed out 6 times between 07/17/24 to 07/28/24 by Nurse #1. The dates oxycodone was signed out were twice on 07/23/24, 07/24/24, twice on 07/27/24, and on 07/28/24. 1e. Resident #281 was admitted to the facility on 07/11/24 with diagnoses that included arthritis in right knee and pain in right and left knee. Resident #281's physician orders included an order dated 07/11/24 for oxycodone 5 mg one tablet by mouth every 6 hours PRN for moderate to severe pain. The medical record indicated Resident #281 resided in the facility 7/17/24 through 7/28/24. Resident 281's MAR revealed that oxycodone was documented as administered 2 times between 07/17/24 to 07/28/24 by Nurse #1. The dates of administration were 07/19/24 and 07/27/24. The pharmacy-controlled drug record revealed that oxycodone was signed out 5 times by Nurse	F 602		

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 10/02/2024

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 602	Continued From page 4 #1 between 07/17/24 and 07/28/24. The dates oxycodone was signed out were 07/19/24, 07/22/24, 07/24/24, 07/27/24 and 07/28/24. 1f. Resident #280 was admitted to the facility on 06/30/24 with diagnoses that included fracture of left femur. Resident #280's physician order included an order dated 06/30/24 for oxycodone 5 mg by mouth every 4 hours PRN for pain. The medical record indicated Resident #280 resided in the facility 7/17/24 through 7/28/24. Resident #280's MAR revealed that from 07/17/24 to 07/28/24 oxycodone was documented as administered 2 times by Nurse #1. The dates of administration were 07/22/24 and 07/28/24. The pharmacy-controlled drug record for Resident #280 revealed that oxycodone was signed out 6 times by Nurse #1 between 07/17/24 and 07/28/24. The dates oxycodone was signed out were 07/22/24, 07/23/24, 07/24/24, twice on 07/27/24, and 07/28/24. On 10/02/24 at 10:34 AM, a telephone interview with Nurse #2 revealed on 07/28/24 she arrived and counted the narcotics in medication carts with Nurse #1. On the 700-hall cart, 4 cards of narcotics did not reconcile with the pharmacy-controlled drug record. Nurse #2 stated that she then counted the narcotics on the 600-hall cart with Nurse #1. This count revealed that the medications were reconciled, but there were medication cards that had tape on the back. She reported that she could tell that "something was off". She called the Director of Nurses (DON) and then the Administrator.	F 602		

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 10/02/2024

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 602	Continued From page 5 On 10/02/24 at 10:40 AM, a telephone interview with Nurse #1 was attempted and unsuccessful. On 10/02/24 at 9:13 AM, an interview was conducted with the DON who reported that on the night of 07/28/24, Nurse #2 reported that Nurse #1 was "different" and there was concern about medication discrepancy, the Administrator was called. The DON indicated the Administrator came in and was in the facility while Nurse #1 completed her documentation. Nurse #1 was sent home until further notice. The DON reported she called Nurse #1 to come in the next day. During the interview with the Administrator in the conference room, Nurse #1 admitted that she diverted the medications and that she "had a problem". Law enforcement was called, and Nurse #1 was arrested. The Director of Operations reported that this Nurse #1 had no previous allegations with the Board of Nursing. On 10/02/24 at 10:02 AM, an interview was conducted with the Director of Operations and the Administrator. The Administrator reported that Nurse #1 had been in orientation for 9 days. The first night Nurse #1 had worked independently with access to the medication cart was 07/28/24. The Administrator reported that he got a call on 07/28/24 from Nurse #2 about medication discrepancy concerns. He stated he arrived at the facility at midnight and Nurse #1 was still on-site. He observed Nurse #1 had completed her documentation, and he informed Nurse #1 to go home until further notice. The Administrator and Director of Operations reported that they audited all the MARs and noted diversion in the medication carts for 600 and 700 halls only with Nurse #1. After the audit of the MAR monitoring	F 602		

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 10/02/2024

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 602	Continued From page 6 of the MARs began. The facility provided the following action plan with a completion date of 07/29/24: 1.Corrective action for residents(s) affected by the alleged deficient practice: On 07/29/24, termination of Nurse #1, reporting the nurse to law enforcement, reporting the misappropriation to the state agency, reporting the nurse to the state board of nursing. On 07/29/24, Director of Operations and Administrator assessed if affected residents had any issues during their stay with receiving either the scheduled or PRN pain medications. 2.Corrective action for residents (s) with the potential to be affected by the alleged deficient practice: A full audit of all narcotic sheets of all residents was completed on 07/29/24 to ensure no other discrepancies or trends were noted with any other nurses signing out medications. 3.Measures/Systemic changes to prevent recurrence of deficient practice: On 07/29/2024 at approximately 04:30 PM, education to all nurses and med-aides was started by the DON related to abuse (specifically diversion of drugs/misappropriation), reporting of concerns/abuse, as well as the narcotic count process. All nurses on the 3rd shift (11:00 PM-07:00 AM) of 07/29/24 were educated and no other nurse was allowed to work on going until being educated. On 7/29/24 a Quality Assurance and Performance Improvement (QAPI) committee meeting was held immediately after discovering the area of	F 602		

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 10/02/2024

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 602	Continued From page 7	F 602		

concern with appropriate QAPI members, to include Administrator, Director of Operations, Director of Nursing, and Nurse Managers. QAPI members discussed and approved the plan of correction as written. QAPI members agreed to monitor this plan in the monthly meeting. Should any areas of concern arise between meetings, the appropriate committee members will address timely and accordingly.

4.Monitoring procedure was started on 7/29/24 to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and sustained:

To help ensure this plan of correction remains effective, the Director of Operations or designees will review 5 narcotic sheets per week X4 weeks to ensure the medication sign outs for the previous week match the MAR for the residents. Should the residents be alert and oriented, the Director of Operations or designee will also interview that resident and ensure they receive the medication as requested on the dates it was documented. Should substantial compliance continue to be found, this monitoring tool will be reduced to 5 sheets per month until the next recertification survey.

This Plan of Correction will be followed and reviewed by the Quality Assurance and Performance Improvement (QAPI) committee 8/14/24 who will reassess the need for continuation of this monitoring tool. This Plan of Correction will be followed and reviewed by the QAPI committee and areas of concern will be addressed immediately by the 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 10/02/2024

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 602	Continued From page 8 Correction Date was 7/29/24.	F 602		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to post cautionary and safety signage outside of resident rooms that indicated the use of oxygen for 2 of 2 residents reviewed for respiratory care (Residents #15 and #34). This practice had the potential to affect other residents receiving supplemental oxygen. The findings included: a. Resident #15 was admitted to the facility on 8/3/22 with the diagnosis of Chronic Obstructive Pulmonary Disease (COPD). A review of Resident #15's physician orders dated 8/3/22 revealed an order for oxygen to be administered continuously via nasal cannula at 2 liters per minute (l/min). A review of the annual Minimum Data Set (MDS) dated 7/31/24 indicated Resident #15 was coded for receiving oxygen.	F 695	For the resident(s) affected: The residents affected per the 2567 were residents #15 and #34. Oxygen cautionary signage which states "Caution: Oxygen in Use" was placed on the outside of the resident #15 and #34 door by the Director of Operations on 11/5/2024. Residents with the potential to be affected: Oxygen cautionary signage was also placed on all other resident's doors of whom have scheduled or PRN oxygen orders. Measures put in place: Oxygen cautionary signage was also placed on all other resident's doors of whom have scheduled or PRN oxygen orders. Monitoring: Once a month x 6 months, starting November 2024, the Administrator or designee will check the doors of all residents with oxygen orders to ensure there is oxygen cautionary signage at outside their door. Should substantial compliance be found, this monitoring tool	11/5/24

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 10/02/2024

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 695	Continued From page 9 Observations on 9/30/24 at 11:34 AM, 10/1/24 at 1:56 PM, and 10/2/24 at 8:17 AM revealed Resident #15 was sitting in her wheelchair in her room wearing a nasal cannula with oxygen being administered at 2 l/min. There was no cautionary or safety signage posted at Resident #15's room to indicate oxygen was in use during the observations. b. Resident #34 was admitted to the facility on 6/12/24 with a diagnosis of COPD exacerbation, acute with chronic respiratory failure with risk of decline, and pneumonia. Resident #34 had a physician's order dated 6/12/24 for oxygen administered at 2 liters per minute by nasal cannula. Review of Resident #34's quarterly MDS dated 9/16/24 revealed she was severely cognitively impaired with no mood or behavioral disturbances. Resident #34 was coded for receiving oxygen. Observations conducted on 10/1/24 at 9:12 AM, 10/2/24 at 8:17 AM, and 10/2/24 at 11:02 AM revealed there was no cautionary signage at Resident #34's room indicating oxygen was in use. Resident #34 was in her room using oxygen delivered by nasal cannula during the observation times. An interview was conducted with Nurse #1 on 10/02/24 at 11:02 AM. She stated she had not seen any oxygen in use signs posted in the facility, and she did not recall placing one in any resident's room. Nurse #1 stated that since the facility was smoke free, she didn't think they needed oxygen in use signage. She stated that	F 695	will be reduced to quarterly until the next recertification survey. This plan of correction will be followed closely by the Quality Assurance Performance Improvement Committee. Any areas of concern will be address timely and accordingly. Based on the results of the monitoring, the QAPI committee will determine the frequency of this monitoring after the next recertification survey.	

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 10/02/2024

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 695	Continued From page 10	F 695		

the staff educated family members regarding no smoking around oxygen.

On 10/2/24 at 1:55 PM an interview was conducted with the Director of Nursing (DON). She verbalized the facility had 11 total residents using oxygen. The DON stated the facility did not use oxygen signage. She further stated that since the building was smoke-free she didn't think the facility was required to use individual no smoking signs.

An interview with the Administrator was conducted on 10/2/24 at 2:04 PM. He stated it was illegal for indoor smoking in North Carolina facilities. He stated since the facility was smoke-free it was unnecessary to post signs of no smoking in the residents' rooms. He stated he had posted no smoking signage at the facility's entrance.