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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50642 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: 1a. Resident #66 was admitted on [DATE] 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 [DATE] 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. (continued on next page)

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.

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

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 [DATE] 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 [DATE] 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 [DATE] with diagnoses that include pain in right knee and right foot. 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 [DATE] 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. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The pharmacy-controlled drug record revealed that oxycodone was signed out 5 times by Nurse #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 [DATE] 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. 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 of the MARs began. The facility provided the following action plan with a completion date of 07/29/24: (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. Correction Date was 7/29/24.