STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345024	A. BUILDING _____ B. WING _____	C 11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS NURSING CENTER INC	5229 APPOMATTOX ROAD PLEASANT GARDEN, NC 27313

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #03CJ11	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to make fluids available to 1 of 3 residents (Resident #79) who were unable to request something to drink in between meals. Findings included: Resident #79 was admitted to the facility initially on 10-28-08 and then readmitted on 5-18-15 with multiple diagnoses that included cerebrovascular disease, coronary artery disease, atrial fibrillation, dementia and moderate protein calorie malnutrition. Resident #79's care plan dated 9-5-18 revealed a goal that the resident "will have basic needs communicated daily." The interventions for that goal were as followed; observe resident for basic needs, maintain consistent and predictable routine and anticipate needs. Goal number 2 for Resident #79 was that he would be free from signs and symptoms of a urinary tract infection. The interventions for that goal were as followed;	F 558	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 December 7, 2017 survey and does not constitute an agreement or admission of Clapp's Nursing Center 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 December 27th, 2018.	12/27/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/21/2018

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F 558	Continued From page 1 encourage and assist with fluids, monitor intake and output, monitor for signs and symptoms of dehydration. The quarterly Minimum Data Set(MDS) dated 10-24-18 revealed Resident #79 was severely cognitively impaired and needed extensive assistance with one person for eating. The resident was not coded for any behaviors or mood issues. A review of the quarterly dietary review dated 10-24-18 revealed the resident was on a pureed diet with need for tray set up with follow up for assistance and feeding. The review documented the resident did not use adaptive equipment and did not receive supplements. An observation and resident interview was conducted on 11-26-18 at 3:30pm. Resident #79 motioned that he wanted a drink. The resident's room did not have a water pitcher, juice or any other type of fluids available for the resident. When asked to put on his call bell for staff assistance, Resident #79 was not able to use his call bell to call for assistance. On 11-27-18 at 8:35am Resident #79's room was observed not to have a water pitcher, juice or any other fluids available for the resident. During an interview on 11-27-18 at 8:35am with the activities assistant who was feeding Resident #79 she stated the resident was not on any fluid restrictions that she was aware of and thought the resident may not have a water pitcher because the facility was replacing them in some of the resident's rooms.	F 558	For the resident affected: As soon as the facility was made aware on 11/27/2018 that resident #79 did not have a water pitcher in his room, the Assistant Administrator took a water pitcher filled with water and ice to the room. An in-service was started to all nursing staff on 11/27/2018 and completed by 12/21/2018, including both Part-Time and Full-Time Licensed Nurses and Certified Nursing Assistants, regarding the importance of ensuring all residents have a water pitcher in the room which is accessible to resident, provided they are not on a fluid restriction or thickened liquid diet. All nurses and CNAs were educated on where to look in a resident's chart to find out if resident is or is not on a fluid restriction, specialty diet or require assistance, cueing, and/or encouragement for drinking from water pitcher. For the residents with the potential to be affected: On 11/27/2018, the Assistant Administrator, both Unit Supervisors and the Director of Nursing checked all resident rooms in the facility to ensure all residents who were not on a fluid restriction or thickened liquid diet had a water pitcher at the bedside, accessible to the resident. It was found at that time all other residents did have a water pitcher filled with water and ice at the bedside, accessible to them. An in-service was started to all nursing staff on 11/27/2018 and completed by 12/21/2018, including both Part-Time and Full-Time Licensed	

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F 558	Continued From page 2 An interview with nurse #1 occurred on 11-27-18 at 3:52pm. The nurse stated Resident #79 was not on any fluid restrictions and that he received fluids on his meal tray and with his medications. The nurse also stated he was unaware Resident #79 did not have a water pitcher in his room. Nursing Assistant (NA) #1 was interviewed on 11-27-18 at 3:58pm and she stated she had already replenished the residents water in their rooms but that she did not know why Resident #79 did not have any but thought he was on fluid restriction. She also stated she did not offer the resident any fluids during the shift other than at meal times. The NA denied ever seeing Resident #79's call light on so she did not know if the resident was able to use his call light to obtain staff assistance. During an interview with Nursing Assistant (NA) #2 on 11-28-18 at 8:10am she stated she "usually" made sure the residents had something to drink in their rooms in-between meals and did not know why Resident #79 did not have any thing in his room. She also stated she had only offered fluids to Resident #79 during meal times. NA #2 stated Resident #79 sat in the dayroom most of the day and that she had not seen him use his call bell. The Administrator and Director of Nursing were interviewed on 11-28-18 at 3:50pm. The Administrator stated the resident could ask for something to drink in between meals and he believed the residents had water pitchers in their rooms. He also stated he expected his staff to follow Federal Regulations and indicated that every resident should have a water pitcher in their room.	F 558	Nurses and Certified Nursing Assistants, regarding the importance of ensuring all residents have a water pitcher in the room which is accessible to resident, provided they are not on a fluid restriction or thickened liquid diet. All nurses and CNAs were educated on where to look in a resident's chart to find out if resident is or is not on a fluid restriction, specialty diet or require assistance, cueing, and/or encouragement for drinking from water pitcher. Measures put in place: An in-service was started to all nursing staff on 11/27/2018 and completed by 12/21/2018, including both Part-Time and Full-Time Licensed Nurses and Certified Nursing Assistants, regarding the importance of ensuring all residents have a water pitcher in the room which is accessible to resident, provided they are not on a fluid restriction or thickened liquid diet. All nurses and CNAs were educated regarding where to find in a resident's chart if a resident is, or is not, on a fluid restriction, specialty diet or require assistance, cueing, and/or encouragement for drinking from water pitcher. This in-service was completed by the Staff Development Coordinator and Nurse Supervisor. Monitoring: To ensure on-going compliance with F558, the Director of Nursing or Unit Managers will check all resident rooms weekly x 3 to ensure all residents who are not on a fluid restriction or thickened liquid diet have a water pitcher at their bed side which is	

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F 558	Continued From page 3	F 558	accessible to them. If substantial compliance is found after checking all residents weekly x 3, the quality improvement monitoring will be reduced to all residents per month x 3 months. Should substantial compliance remain to be found, the monitoring will then be reduced to quarterly x 3. This plan of correction as well as the quality improvement monitoring will be addressed in the facility QAPI committee meeting and, should any issues arise, will be addressed by the committee timely.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		12/27/18

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F 656	Continued From page 4 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive plan of care for a resident with recurrent urinary tract infections (UTI ' s). This was evident for 1 of 4 residents reviewed for UTI ' s (Resident #50). Findings Included: Resident #50 was admitted to the facility on 3/29/18 and diagnoses included cerebral vascular accident with left sided hemiplegia and diabetes. A quarterly minimum data set (MDS) dated 9/28/18 for Resident #50 revealed a diagnosis of a UTI within the past 30 days. Review of the medical record for Resident #50 revealed she was treated with antibiotics for UTI ' s on 4/16/18, 6/6/18, 8/9/18 and 9/6/18.	F 656	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 December 7, 2017 survey and does not constitute an agreement or admission of Clapp□s Nursing Center 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	

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F 656	Continued From page 5 An interview on 11/29/18 at 11:32 am with the MDS Nurse revealed if a resident had a pattern of UTI ' s with antibiotic treatment there should be a care plan developed that addressed the potential for and / or actual UTI. She stated there should be interventions identified on the care plan for treatment of a UTI and prevention of UTI ' s. An interview on 11/29/18 at 1:24 pm with the Director of Nurses revealed it was her expectation that UTI ' s were care planned.	F 656	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 December 27th, 2018. For the resident affected: On 11/29/18, a new area within resident #52's care plan was developed to address Urinary Tract Infection history with goals/interventions established. For residents with the potential to be affected: Care plans were revised for all residents who had experienced a Urinary Tract Infection within the previous 30 days prior to 11/30/18. Education was also provided to both Minimum Data Set Coordinators on 12/13/2018 related to implementing and developing a new care plan area for residents who are diagnosed with a Urinary Tract Infection. This education was conducted by the Staff Development Coordinator. Measures put in place: Education was also provided to the Minimum Data Set Coordinators on 12/13/2018 related to implementing and developing a new care plan area for residents who are diagnosed with a Urinary Tract Infection. This education was conducted by the Staff Development Coordinator. Monitoring: Quality Improvement Monitoring will be conducted on 5 residents per month x 3 quarters who have been diagnosed with a Urinary Tract Infection. Should substantial compliance	

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F 656	Continued From page 6	F 656	be found after monthly monitoring, the monitoring will then be reduced to 5 residents per quarter x 3 quarter. 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 657 SS=D	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	F 657		12/27/18

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F 657	Continued From page 7 assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to revise a care plan for a resident with significant weight loss. This was evident for 1 of 5 residents reviewed for nutrition (Resident #91). Findings Included: Resident #91 was admitted to the facility on 7/27/18 and diagnoses included protein calorie malnutrition, diverticulitis of intestine, diabetes, anemia and Alzheimer ' s Disease. A care plan dated 8/2/18 for Resident #91 stated the resident was ordered a therapeutic, mechanically altered diet related to diabetes management. Intakes were good to fair, resident was able to feed self. Supplementation provided for additional nutritional support related to infection. Interventions included to monitor weight, intake and labs per facility protocol. A quarterly minimum data set (MDS) dated 11/1/18 for Resident #91 revealed she had experienced a significant weight loss, was not on a prescribed weight loss program and current weight was 199 pounds (lbs.). Review of the medical record for Resident #91 revealed a weight of 197.2 lbs. on 11/16/18, 198.8 lbs. on 10/19/18, 203 lbs. on 10/5/18, 207.6 lbs. on 9/10/18 and 223.4 lbs. on 5/4/18. This reflected an 11.6% weight loss in 6 months. An interview on 11/29/18 at 9:30 am with the Registered Dietitian (RD) revealed she had	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 November 26, 2018 survey and does not constitute an agreement or admission of Clapp□s Nursing Center 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 December 27th, 2018. For the resident affected: On 11/29/2018, Resident #91's care plan was updated by the facility Dietitian to reflect Resident #91's significant weight loss and the intervention/goals put in place by the facility. For the residents with the potential to be affected: All other residents with current significant weight loss over the last 30, 90, and/or 180 days were reviewed to ensure	

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F 657	Continued From page 8 started working at the facility in July 2018. She stated a resident with significant weight loss should have their care plan updated with the weight loss and any new interventions. The RD explained there was some inconsistency with this process and she had not updated Resident #91 ' s care plan with the significant weight loss. An interview on 11/29/18 at 11:37 am with the MDS nurse revealed dietary staff were responsible for updating the care plans when residents experienced a significant weight change. She stated Resident #91 ' s care plan should have been updated. An interview on 11/29/18 at 1:28 pm with the Director of Nurses and Administrator revealed they expected care plans to be updated for residents when their health condition changed.	F 657	significant weight loss has been care planned. No other issues we found with care planning of significant weight loss. The Dietitian was educated on 12/13/2018 by the Staff Development Coordinator on the requirement of timely revising/updating care plans of residents with significant weight loss. Measures put in place: The Dietitian was educated on 12/12/2018 by the Staff Development Coordinator on the requirement of timely revising/updating care plans of residents with significant weight loss. Monitoring: To ensure on-going compliance, the care plans of five residents with significant weight loss will be reviewed per month x 3 months to verify the significant weight loss has been care planned with appropriate interventions and goals in place. This quality improvement monitoring will be completed by the Dietary Manager or MDS Coordinator. 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 be followed by the facility's Quality Assurance Performance Improvement Committee and any areas of concern will be addressed timely and appropriately.	
F 677	ADL Care Provided for Dependent Residents	F 677		12/27/18

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F 677 SS=D	Continued From page 9 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews the facility failed to provide grooming to include removal of facial hair for a resident that was dependent on staff. This was evident for 1 (Resident #99) of 4 residents reviewed for activities of daily living (ADLs). Findings Included: Resident #99 was admitted to the facility on 3/27/18 and diagnoses included multiple sclerosis, functional quadriplegia and contractures. A task care plan dated 3/27/18 for Resident #99 identified she required AM and PM care by the nursing assistants (NAs), was scheduled for a whirlpool on Mondays and a shower on Wednesdays. A quarterly minimum data set (MDS) dated 11/9/18 for Resident #99 revealed she required extensive, one-person assist with personal hygiene, was not coded for refusal of care and her cognition was intact. An observation on 11/26/18 at 1:10 pm of Resident #99 revealed she was lying in bed and noted to have dark facial hair above and below her lips that extended around the sides of her face and chin. Resident #99 stated the staff hadn	F 677	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 November 26, 2018 survey and does not constitute an agreement or admission of Clapp□s Nursing Center 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 December 27th, 2018. For the resident affected: Resident #99 was shaven on 11/26/2018 by the second shift CNA. For the residents with the potential to be affected: All residents were checked on 11/29/18 to ensure no other residents	

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F 677	Continued From page 10 ' t shaved her in 3 days and she didn ' t know why. Resident #99 added she didn ' t want to have facial hair and didn ' t want to look like a man. An interview on 11/27/18 at 2:51 pm with Nursing Assistant (NA) #5 revealed she was familiar with Resident #99. She stated the resident required total care that included shaving her facial hair. NA #5 added this should be done every other day or when the resident requested. An interview on 11/28/18 at 10:47 am with NA #6 revealed she was the NA for Resident #99 on 11/26/18. She stated this was her first day working with the resident on her own. NA #6 added she remembered providing a bed bath for the resident but could not recall if she had shaved her face. She stated that she would have documented what care she had provided for the resident in the kiosk. An interview on 11/28/18 at 10:51 am with Nurse #5 revealed she was the nurse for Resident #99. She stated the NAs should include shaving of facial hair as part of routine care and it should be provided daily or as needed. An interview on 11/28/18 at 10:56 am with Nurse Manager #6 revealed Resident #99 was currently receiving hormone replacement and that contributed to the increase in the resident ' s facial hair. She stated residents should be shaved daily, not just on their whirlpool or shower days. She explained each resident had a task care plan and shaving was a part of routine AM care. Review of the NA documentation with Nurse Manager #6 for Resident #99 revealed shaving had not been identified as being completed on	F 677	were in need of being shaven. No other residents were in need of being shaven at that time. An in-service was started on 12/3/2018 and completed by 12/21/2018 to all Full-time and Part-time Certified Nursing Assistants regarding the importance of facial hair being shaven for all residents on whirlpool and shower days when hair is visible on face or as requested by the resident/responsible party of resident. Re-education was also provided during the in-service to all certified nursing assistants on how to check off on care provided via the residents' task care plan on the kiosks. The in-service also included education to all CNAs on how to document and report when residents refuse care being offered to them. This in-service was completed by the Staff Development Coordinator and Nurse Supervisor. Measures put in place: An in-service was started on 12/3/2018 and completed by 12/21/2018 to all Full-time and Part-time Certified Nursing Assistants regarding the importance of facial hair being shaven in all residents per their task care plan and as requested by the resident/responsible party of resident. Re-education was also provided during the in-service to all certified nursing assistants on how to check off on care provided via the residents' task care plan on the kiosks. The in-service also included education to all CNAs on how to document and report when residents refuse care being offered to them. This in-service was completed by the Staff Development Coordinator and	

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	345024	A. BUILDING _____ B. WING _____	C 11/29/2018

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F 677	Continued From page 11 11/24/18, 11/25/18 or 11/26/18. An interview on 11/29/18 at 1:33 pm with the Director of Nursing and the Administrator revealed it was their expectation that residents receive grooming that included removal of facial hair as needed.	F 677	Nurse Supervisor. Monitoring: To ensure on-going compliance, the Director of Nursing or Unit Managers will conduct performance improvement monitoring on 10 residents per week x 3 weeks to ensure all residents have been shaven appropriately. If substantial compliance is found during weekly monitoring, the quality improvement monitoring will then be reduced to 10 residents per month x 3 months. Should substantial compliance be found during the monthly monitoring, the quality improvement monitoring will then be discontinued. This plan of correction as well as the quality improvement monitoring will be addressed in the facility QAPI committee meeting and, should any issues arise, will be addressed by the committee timely.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		12/27/18

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F 812	Continued From page 12 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to allow cookware to air dry before being stored and failed to ensure dishes were stacked clean on the food service tray line. Findings included: During an observation of the kitchen on 10-26-18 at 10:00am with the Dietary Manager the following issues were found: 1. 1 small rectangle metal pan had small brown pieces stuck to the sides of the pan. 2. 2 large steam pans were stacked wet. 3. 10 clear plastic dessert cups were placed in a plastic container that had water in the bottom and the dessert cups were stacked together wet. 4. 16 plastic soup bowls had food particles lining the bottoms and sides of the bowls and the upper rims of the bowls were worn and stained. 5. 6 ceramic dinner plates had food particles on the plate. 6. 3 plastic divided plates located on the tray line had food particles stuck to the plates. The Dietary Manager was interviewed on 11-26-18 at 10:20am and stated she was not sure what had happened but felt the issues were caused by her weekend staff and that she would speak with them about making sure cookware was dry and the dishes clean before stacking them.	F 812	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 November 26, 2018 survey and does not constitute an agreement or admission of Clapp□s Nursing Center 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 December 27th, 2018. For the resident affected: No resident was affected by this observation. For the residents with the potential to be affected/measure put in place: All bowls were replaced with new bowls to eliminate the possibility of any stains. In addition, a	

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F 812	Continued From page 13 An interview was conducted with the Administrator and the Director of Nursing on 11-28-18 at 3:50pm. The Administrator stated he had spoken with the kitchen staff about not heating soup in the plastic bowls. He said he expected his staff to follow the Federal Regulations.	F 812	new procedure for stacking the dishes up to dry was put in to place on 11/26/2018. All dietary staff, including all full-time, part-time and PRN staff, were educated on the following dish washing/drying procedure: 1. All spoiled pans/pots are taken to the dish room. 2. Then any remaining food placed in the trash. 3. Pots are rinsed to continue removing food residue. 4. They are washed, rinsed and sanitized in the dish machine. 5. They are sanitized using chemical sanitation, not high temperatures. 6. Once washed and sanitized they are removed and placed on a drying rack. 7. The dishes are to be stacked in a criss-cross design in order to allow more air flow the drying process to occur. 8. Once they dry, then they are stacked for storage. All staff were in-serviced on the above process by 11/28/2018. All Staff, including Full-Time, Part-Time and PRN employees, were also in-serviced by the Dietary Manager on the requirement of checking all dishes and cookware prior to stacking on the tray line to ensure there are no food particles stuck to the dishes or cookware. All staff were in-serviced that should any dishes have food particles then they must but run back through the dish machine until completely clean. This in-service was complete by 12/21/2018. Monitoring for continued compliance: The dietary manager will audit the dishes once	

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F 812	Continued From page 14	F 812	per day x 3 days to ensure no moisture, food particles or stains are found. If substantial compliance is found, the audit will be reduced to once per week x 3 weeks. After the weekly audit, the audit will be reduced to monthly x 3 months. Should substantial compliance be found after the monthly audit is complete, the audits will then be discontinued. This plan of correction will be brought to the QAPI committee at the next meeting and any issues that arise will be addressed immediately.	
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 observations, record review, and staff interviews the facility ' s Quality Assessment and Performance Improvement Committee (QAPI) failed to maintain implemented procedures and monitor the interventions that were put in place following the annual recertification of 12/7/17. This was for a recited deficiency in the area of development of a comprehensive care plan (F-656). This deficiency was re-cited during the annual recertification and complaint survey of 11/29/18. The continued failure of the facility during 2 federal surveys of record showed a pattern of the facility ' s inability to sustain and effective QAPI program.	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 November 26, 2018 survey and does not constitute an agreement or admission of Clapp□s Nursing Center 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,	12/27/18

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F 867	Continued From page 15 Findings included: This tag is cross referenced to: F 656 - Based on record review and staff interviews the facility failed to develop a comprehensive plan of care for a resident with recurrent urinary tract infections (UTI ' s). This was evident for 1 of 4 residents reviewed for UTI ' s (Resident #50). During the recertification survey of 12/7/17 the facility was cited for failure to develop a care plan for 1 o 4 residents (Resident #64) who had an indwelling catheter, utilized a communication book and had a diagnosis of seizure disorder. An interview on 11/29/18 at 1:50 pm with the Administrator revealed he expected the staff to follow state regulations.	F 867	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 December 27th, 2018. The Administrator held a Quality Assurance Performance Improvement meeting on 12/20/18 with the committee members which included the Director of Nursing, Social Services, Dietary Manager, Minimum Data Set Coordinators, Nurse Supervisors and Staff Development Coordinator 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 12/20/18 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 identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The	

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F 867	Continued From page 16	F 867	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 Administrator. 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.	