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 10/13/2016

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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to honor Resident #167 ' s choice to be served a Mechanical Soft sandwich at lunch and supper. This was evident in 1 of 4 residents in the sample reviewed for choices. Findings Included: Resident #162 was admitted to the facility on 12/7/15 with the following diagnosis: Major Depression, Anxiety Disorder, Protein-Calorie Malnutrition and Rheumatoid Arthritis. A review of Resident #162 ' s annual comprehensive minimum data set (MDS) dated 9/16/16 revealed that she required extensive assistance with eating, had experienced significant weight loss and had moderately impaired cognition. A review of Resident #167 ' s care plan dated 9/15/16 revealed that she was at high nutritional risk related to receiving a mechanically altered diet with poor to fair meal intake. The goal for Resident #167 was she would not experience any significant weight changes and would tolerate diet as ordered during the next 90 days. The	F 242	F242 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 10/10/2016 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 11/9/2016 For the Residents affected: Resident	11/9/16

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

Electronically Signed | 11/04/2016

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F 242	Continued From page 1 approaches for Resident #167 included: Provide diet and supplements as ordered and honor food preferences. A review of the nutritional therapy evaluation dated 9/15/16 for Resident #167 revealed she received a Puree diet with a Mechanical Soft sandwich at the lunch and dinner meals and her average meal intake was 25 to 50%, A review of the October 2016 physician (MD) orders for Resident #167 revealed an order for a Puree diet with a Mechanical Soft sandwich at lunch and dinner. A review of the MD progress note dated 10/7/16 for Resident #167 revealed that the resident had complained about receiving puree food and that her Responsible Party (RP) would like a Speech Therapy consult. The family would like her to receive a diet that would alternate between Mechanical Soft and Puree foods and would consider signing a waiver to allow the resident to eat the foods she likes for quality of life. The note also included that weight loss was anticipated for the Resident #167 with disease progression. An order was written on 10/7/16 for a Speech Therapy consult for diet upgrade. An observation of Resident #167 on 10/10/16 at 12:29 pm revealed she was sitting up in bed. Her lunch tray was delivered to her room. The meal card on her tray identified her name and a diet order for a Puree diet with a Mechanical Soft sandwich at lunch and supper. Her meal tray included a plate of puree food, a container of ice cream and 2 beverages. There was not a Mechanical Soft sandwich on the meal tray. The nursing assistant began feeding her and the	F 242	(#167 or #162, 2567 is unclear which resident it is referring to) meal ticket was reviewed and resident received a sandwich for lunch and dinner as the resident requested. For the Residents with the potential to be affected and measures put in place: On 10/24/2016 an all dietary staff in-service was held to review placing everything that is written on a resident's meal ticket is placed on the resident's tray. On 10/24/16 a new Dietary Manager was hired to ensure the Dietary department is managed more efficiently. Monitoring: Dietary Manager or designee will audit ten trays a day, five days a week for four weeks. Then auditing thirty trays a month for two months. The tray audits will begin on 11/7/2016. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	

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F 242	Continued From page 2	F 242		

Mechanical Soft sandwich was not provided.

An observation of Resident #167 on 10/12/2016 at 5:59 pm revealed she was sitting up in bed. The meal card on her tray identified her name and a diet order for a Puree diet with a Mechanical Soft sandwich at lunch and supper. Her meal tray included a plate of puree food, a bowl of puree dessert and 2 beverages. There was not a Mechanical Soft sandwich on the meal tray. The nurse entered the room and stated she was coming to feed her; the Mechanical Soft sandwich was not provided.

An interview with the Registered Dietitian (RD) on 10/13/16 at 9:33 am revealed that Resident #167 has had problems with not eating well. She stated that she received a Puree diet with a Mechanical Soft sandwich at lunch and supper. She stated that Resident #167 should have received a Mechanical Soft sandwich at her lunch and supper meals.

An interview with the Dietary Manager on 10/13/16 at 11:14 am revealed that the diet order for Resident #167 was for a Puree diet with a Mechanical Soft sandwich at lunch and supper. He stated that she should have received the Mechanical Soft sandwich and confirmed that the sandwich was documented on her tray card. He stated that the dietary staff on the tray line should be checking the tray cards for accuracy.

An interview with the facility Administrator on 10/13/2016 at 2:26 pm revealed that his expectation was that Resident #167 should have received the Mechanical Soft sandwich with her lunch and supper meals as ordered by the physician.

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F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately for 1 of 3 residents reviewed for incontinence (Resident #112). The facility failed to accuracy code on the MDS the dental status for 1 of 3	F 278	F278 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.	11/9/16

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F 278	Continued From page 4 residents reviewed for nutrition. (Resident #162) 1. Resident #112 was admitted to the facility on 5/23/16 with cumulative diagnoses which included hypertension and diabetes. Record review of the titled " Bladder " form (used by the Nursing Assistant (NA) to document whether the resident was continent or incontinent of urine) dated 5/27/16-6/02/16 revealed on 5/27/16 at 8:24 PM the resident was continent of urine. All the other times the resident was noted as incontinent of urine. Review of the admission MDS assessment dated 6/2/16 revealed the resident was coded as frequently incontinent of urine. Review of the quarterly MDS assessment dated 8/31/16 revealed the resident was coded as always incontinent of urine. Interview on 10/13/2016 at 10:23 AM with Nurse #3 revealed Resident #112 had always been incontinent of urine and bowels since admission to the facility. Interview on 10/13/2016 at 10:25 AM with NA #1 revealed Resident #112 had always been incontinent of bladder and bowel. Interview on 10/13/2016 at 10:35 AM with NA #2 revealed Resident #112 she had always been incontinent of urine and bowels. NA #2 stated " I do not believe the resident could ever be continent of urine due to her mental status. " Continued interview with NA #2 revealed the change in Resident #112 was initially being fed by gastrostomy tube and now eating a pureed diet. Interview on 10/13/2016 at 2:58 PM with NA #3 revealed her documentation on the bladder form for 5/27/16 regarding continence of urine was coded in error. NA #3 stated Resident #112 had	F 278	Preparation and submission of this plan of correction is in response to DHHS 2567 for the 10/10/2016 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 11/09/2016. For the Resident affected: The admission assessment dated 6/2/2016 for resident #112 was corrected on 10/12/2016 The assessment dated 9/16/2016 for resident #162 was corrected on 10/13/2016. For the Residents with the potential to be affected and measures put in place: Re-education was completed on 11/1/2016 by administrator for both MDS Coordinators on investigating all coding outliers when they do not seem to be in accordance with a resident's current functional ability. If errors are found, the MDS Coordinator is to make corrections accordingly in order to complete an accurate MDS assessment. The in-service also reviewed the importance of assessing the resident in person instead of relying only on documentation. Both of	

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F 278	Continued From page 5 been always incontinent of urine. The MDS coordinator who conducted the assessment on 6/02/16 was no longer employed at the facility and an interview was unsuccessful. Interview on 10/13/2016 at 3 PM with the Director of Nursing revealed the facility had made attempts to review the MDS assessments for accuracy by the use of a new program that would monitor for discrepancies. Interview on 10/13/2016 at 3:07 PM with the Administrator revealed he expected the MDS assessment be accurate. 2. Resident #162 was admitted to the facility on 12/7/15 and her diagnosis included: Protein Calorie Malnutrition, Major Depression, Anxiety Disorder and Rheumatoid Arthritis. A review of Resident #162 ' s admission Nursing Assessment dated 12/8/15 revealed the resident had her own teeth and was edentulous. A review of Resident #162 ' s Speech Therapy evaluation dated 7/6/16 to 8/4/16 revealed that the resident had missing teeth. A review of the annual comprehensive Minimum Data Set (MDS) for Resident #162 dated 9/16/16 revealed her cognition was moderately impaired and she required extensive assistance with her activities of daily living (ADL ' s). The resident ' s MDS Assessment did not identify any dental concerns. An observation of Resident #162 on 10/12/16 at 5:59 pm revealed she was sitting up in bed and her dinner meal of a puree diet was in her room.	F 278	the facility's MDS Coordinators have been registered for a MDS Coordinator refresher class on 11/30/16 and 12/1/16. From 10/17/2016 through 10/31/2016 the facility audited the last Minimal Data Set completed for all residents to ensure accuracy each resident's Minimal Data Set. Any identified significant errors will be corrected per the RAI manual. Monitoring: An audit will be completed by the MDS coordinators or designee weekly for 3 months on 5 resident's Minimum Data Sets to ensure the Minimum Data Set is completed accurately. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding accuracy of Minimal Data Sets will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	

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F 278	Continued From page 6 The resident vocalized that her teeth hurt. An interview with MDS Nurse #1 and MDS Nurse #2 on 10/13/16 at 8:58 am revealed that they had not completed the resident ' s MDS dated 9/16/16. An observation of Resident #162 with MDS Nurse #1 and MDS Nurse #2 revealed an examination of Resident #162 ' s mouth by MDS Nurse #1. She stated that she observed a cavity and missing teeth. She also stated that she would code Section L of the MDS for this resident as " decay and missing teeth " and she was going to do a correction to the MDS dated 9/16/16. An interview with MDS Nurse #1 and MDS Nurse #2 on 10/13/16 at 4:41 pm revealed that MDS Nurse #2 had completed the MDS dated 9/16/16 for Resident #162. She stated that she was unable to examine the resident ' s mouth during the look back period for Section L of the MDS assessment dated 9/16/16 and she had coded Section L based on the Nurse Practioner ' s note dated 9/13/16. An interview with the Director of Nursing (DON) on 10/13/2016 at 5:00 pm revealed the coding was incorrect for the MDS dated 9/16/16, Section L for Resident #162.	F 278		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329		11/9/16

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F 329	Continued From page 7 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed ensure there were not duplicate medication orders for 1 of 5 residents reviewed for unnecessary medications (Resident #20). Findings included: Resident #20 was admitted on 1/8/16 with the current diagnosis of hypertension, heart failure, bronchospasms and depression. The resident's MDS assessment dated 9/30/16 revealed the resident was cognitively intact. The resident had active diagnoses of hypertension, diabetes, anxiety, depression. The resident was on an antianxiety, antidepressant and a diuretic medication. A physician order dated 1/12/16 stated " okay to use orders for admission. " Standing Admission orders last revised 1/14/10	F 329	F329 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 10/10/2016 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	

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F 329	Continued From page 8 stated for Nausea and/or vomiting to give " Promethazine 25 milligrams (mg) oral or rectal suppository or Intramuscular every 12 hours. A specific order must be obtained from resident ' s Physician for continued administration after 24 hours. " The physician ' s telephone order sheet dated 2/19/16 revealed Promethazine 12.5 mg was ordered by mouth every 12 hours as needed for nausea. The physician ' s monthly orders from 2/2016 through 10/2016 revealed the resident had Promethazine 12.5 milligrams (mgs) ordered by mouth every 12 hours as needed for nausea and Promethazine 25mg ordered by mouth every 12 hours as needed for nausea. The resident ' s Medication Administration Record (MAR) from 2/2016 through 10/2016 revealed the resident had Promethazine 12.5 mg ordered by mouth every 12 hours as needed for nausea. The resident also had another order for Promethazine 25mg ordered by mouth every 12 hours as needed for nausea. Review of the MARs from 2/2016 through 10/2016 revealed both 12.5 mg and 25 mg of Promethazine had being given during those months. Pharmacy reviews were reviewed from 2/2016 through 10/2016. There were no recommendations made for Promethazine. Review of nursing notes from 8/2/16 through 10/1/16 revealed the resident did not have any adverse reactions to medications given. Resident #20 was observed in bed at 10/12/16 at 3:23 PM. The resident was observed lying in bed with no signs or symptoms of adverse reactions to medications noted. No signs of drowsiness were noted. Nurse #1 was interviewed on 10/12/16 at 4:53 PM. She stated that there were two orders for	F 329	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 11/9/2016. For the resident found to be affected: On 10/13/16 an order was received to discontinue Promethazine 25mg for resident #20. To ensure other residents are not affected: Nursing staff was in-serviced by Staff Development Nurse on 10/17/2016, 10/18/2016, 10/19/2016, 10/21/2016, 10/22/2016, 10/27/2016, 10/28/2016, 11/1/2016 ,11/2/2016, and 11/3/2016 on residents having duplicate medication orders. On 10/17/2016, 10/18/2016, and 10/19/2016 an audit of all resident's medication orders was performed by Director of Nursing and Nurse Managers to ensure no other residents had unnecessary medication orders. Any resident whose orders reflected an unnecessary medication, an order was received, from the physician, by the nurse to change the order. On 11/1/16, 11/2/16, and 11/3/16 the facility's consultant pharmacist audited all of the resident's medication orders to ensure all residents are free of unnecessary medications. To ensure on-going compliance: During the monthly consultant pharmacy audit the pharmacist, will audit all orders to check for unnecessary medications. The Director of Nursing or designee will audit	

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F 329	Continued From page 9 Promethazine. One was for Promethazine 12.5mg every 12 hours as needed for nausea and the other was for Promethazine 25mg every 12 hours as needed for nausea. She stated she was not sure which one the resident would get. She stated she needed to look into that. She stated that both were on the MAR for that day. Nurse #2 was interviewed on 10/12/16 at 5:09 PM. She stated they had standing orders of 25mg of Promethazine unless otherwise specified. She stated the resident had orders for both 25 mg and 12.5 mg of promethazine by mouth as needed every 12 hours. Nurse #2 explained that on 2/19/16, the resident had orders for 12.5 mg of Promethazine. She stated that the 25 mg of Promethazine would be only for 24 hours unless the physician prescribed it. She stated that typically if the standing orders were used after 24 hours, then the MD would have to write an order for it. Nurse #2 added that if the physician wrote another order, then the standing order would be discontinued. She reviewed the resident orders in the chart and was unable to find a discontinued order for the 25mg of Promethazine or the 12.5 mg of Promethazine. The pharmacy consultant was interviewed on 10/13/16 at 9:31 AM. She stated that for the pharmacy reviews, she would review each resident ' s chart which includes vital signs, nursing notes for behavioral changes, physician orders, look for diagnosis for each medication and the MAR. She would also look at labs and would make sure the labs were being completed on time. She stated she would normally catch if a resident had two orders for the same medication but was not sure why it wasn ' t caught. She stated that the maximum dose is 50 mg for Promethazine and that having two separate orders for the medication was an oversight. She	F 329	monthly all resident medication orders to check for unnecessary medications. Monitoring: Monthly for three months the Director of Nursing or designee will audit ten resident medication administration records monthly for three months to ensure residents are free from unnecessary medications A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding accuracy of Minimal Data Sets will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	

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F 329	Continued From page 10 stated that Promethazine could be taken every 4 to 6 hrs. She explained an adverse effect of the medication would be drowsiness, and considering the other medications the resident was on, this medication could cause increased drowsiness. The Physician was interviewed on 10/13/16 at 9:57 AM. He stated the lower dose of Promethazine was better for elderly residents and that he thought he wrote for 12.5 mg of Promethazine as needed for nausea. He stated he was not recently made aware of any issues with Promethazine by pharmacy. He stated that the standing admission orders would expire after 24 or 48 hours and then he would write orders for the resident ' s medications. The Director of Nursing was interviewed on 10/13/16 at 11:15 AM. She stated if a resident needed a standing order the Physician would initiate the standing orders. She explained a standing order was supposed to be active for 24 hours only. She stated the pharmacist contacted the physician today (10/13/16) and discontinued the 25mg of Promethazine order. From looking at the MAR, she stated it appeared the standing order was for the 25mg of Promethazine, and that the standing order should have been set up for 24 hours only. She added that she would expect for the nurse to follow up with the physician after 24 hours to determine whether the medication was still needed. A physician telephone order sheet dated 10/13/16 revealed Promethazine 25mg was discontinued.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		11/9/16

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F 428	Continued From page 11 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to ensure the pharmacist identified a medication irregularity to prevent duplicate medication therapy for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #20). Findings included: Resident #20 was admitted on 1/8/16 with the current diagnosis of hypertension, heart failure, bronchospasms and depression. The resident's Minimum Data Set (MDS) dated 9/30/16 revealed the resident was cognitively intact. The resident had active diagnosis of hypertension, diabetes, anxiety, depression, reflux and hypothyroidism. The resident was on an antianxiety, antidepressant and a diuretic medication. A physician order dated 1/12/16 stated " okay to use orders for admission. " Standing Admission orders last revised 1/14/10 stated for Nausea and/or vomiting to give " Promethazine 25mg oral or rectal suppository or Intramuscular every 12 hours. A specific order must be obtained from resident ' s Physician for continued administration after 24 hours. " The physician ' s telephone order sheet dated 2/19/16 revealed Promethazine 12.5 mg was ordered by mouth every 12 hours as needed for	F 428	F428 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 10/10/16 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 11/9/2016. For the Residents affected: Resident #20 25mg of Promethazine was discontinued on 10/13/2016.	

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F 428	Continued From page 12 nausea. Review of the physician ' s monthly orders from 2/2016 through 10/2016 revealed the resident had Promethazine 12.5 milligrams (mgs) ordered by mouth every 12 hours as needed for nausea and Promethazine 25mg ordered by mouth every 12 hours as needed for nausea. The resident ' s Medication Administration Record (MAR) from 2/2016 through 10/2016 revealed the resident had Promethazine 12.5 mg ordered by mouth every 12 hours as needed for nausea. The resident also had another order for Promethazine 25mg ordered by mouth every 12 hours as needed for nausea. Review of the MARs from 2/2016 through 10/2016 revealed both 12.5 mg and 25 mg of Promethazine had being given during those months. Review of Resident #20 ' s monthly Pharmacy reviews from 2/2016 through 10/2016 revealed the facility ' s consultant pharmacist made no recommendations regarding the resident having two different physician orders for Promethazine. Resident #20 was observed in bed at 10/12/16 at 3:23 PM. The resident was observed lying in bed with no signs or symptoms of adverse reactions to medications noted. No signs of drowsiness were noted. Nurse #1 was interviewed on 10/12/16 at 4:53 PM. She stated Resident #20 had two orders for Promethazine. One order was for 12.5mg every 12 hours as needed for nausea and the other was for 25mg every 12 hours as needed for nausea. She stated she was not sure which one the resident would get. She stated she needed to look into that. She stated that both of the resident ' s Promethazine orders were on the resident ' s MAR for that day. Nurse #2 was interviewed on 10/12/16 at 5:09 PM. She stated they will have standing orders of	F 428	For the Residents with the potential to be affected: An audit of all resident medication administration records was completed on 10/17/2016, 10/18/2016, and 10/19/2016 to check for any other resident who may have multiple orders for a single medication. To ensure on-going compliance and monitoring: The consultant pharmacist will compare all standing orders to each resident’s medication administration record on a monthly basis. The Director of Nursing or designee monthly will audit all resident medication administration records to audit the pharmacist. Monitoring: Director of Nursing or designee will review the entire monthly pharmacy review for three months. The Director of Nursing or designee will compare the monthly pharmacist audit to each resident’s medication administration records to ensure the monthly pharmacy report is accurate. Director of Nursing or designee will audit ten resident’s medication administration records to see if there are any unnecessary medications. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modifications and/or training are in order.	

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F 428	Continued From page 13	F 428		

25mg of Promethazine unless otherwise specified. She stated the resident had orders for 25mg and 12.5mg of promethazine by mouth as needed every 12 hours. On 2/19/16, an order was written for the resident to receive 12.5 mg of Promethazine. Nurse #2 stated the physician ' s order written on 01/10/16 for 25 mg of Promethazine would be only for 24 hours unless the physician prescribed it. She stated that typically if the standing orders are used then the physician would have an order for it and if the physician wrote another order, then the standing order would be discontinued. She reviewed the resident ' s physician orders in the chart and was unable to find a discontinued order for the 25mg of Promethazine or for the 12.5 mg of Promethazine.

The pharmacy consultant was interviewed on 10/13/16 at 9:31 AM. She stated that for the pharmacy reviews, she would review each resident ' s chart which includes vital signs, nursing notes for behavioral changes, physician orders, look for diagnosis for each medication and the MAR. She will also look at labs and will make sure the labs are being completed on time. She would normally feel that she would catch if a resident had two orders for the same medication but was not sure why she did not identify that. Resident #20 had two orders for the administration of Promethazine. She stated that the maximum daily dose is 50 mg for Promethazine. The resident having two separate orders for the medication was an oversight. She stated that Promethazine can be taken every 4 to 6 hours. She explained an adverse effect of the medication would be drowsiness, and considering the other medications the resident was on, this medication could cause increased drowsiness.

The Physician was interviewed on 10/13/16 at

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F 428	Continued From page 14 9:57 AM. He stated the lower dose of Promethazine was better for elderly residents. He stated he thought he wrote an order for 12.5 mg of Promethazine as needed for nausea. The physician stated he was not made aware of any issues with Promethazine by pharmacy. He stated that the standing admission orders would expire after 24 or 48 hours and then he would write orders for the resident ' s medications. The Director of Nursing (DON) was interviewed on 10/13/16 at 11:15 AM. She stated that if a resident needed a standing order the Physician would initiate the standing orders. A standing order is supposed to be for 24 hours. The DON stated the pharmacist contacted the physician today (10/13/16) and the physician discontinued Resident #20 ' s order for the administration of 25mg of Promethazine every 12 hours as needed for nausea. The DON explained from reviewing the resident ' s MAR, it appeared the standing order was for the 25mg of Promethazine and the standing order should only be set up for 24 hour hours. The DON stated if the resident had 2 different orders for the same medication, the electronic MAR would not alert the nurse that it ' s the same medication but 2 different doses. The DON stated her expectation for pharmacy reviews was for pharmacy to pick up on duplicate medications orders. Her expectation for medications was to assure setting up standing orders for only 24 hours and then following up with the physician if medication are needed. Further review of Resident #20 ' s medical record revealed a physician ' s telephone order dated 10/13/16 which discontinued the resident ' s order for Promethazine 25mg every 12 hours as needed for nausea.	F 428		
F 520	483.75(o)(1) QAA	F 520		11/9/16

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F 520 SS=D	Continued From page 15 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff and resident interviews, the facility ' s Quality Assurance and Assessment (QAA) Committee failed to maintain procedures and monitor the interventions that the committee put into place following the October 29, 2015 recertification in the areas of Choices (F 242) and Assessment Accuracy (F278). These deficiencies F242 and F 278 were recited on the recertification survey of	F 520	F520 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 10/10/2016 survey and does not constitute an agreement or admission of	

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F 520	Continued From page 16 October 13, 2016. The continued failure of the facility during two consecutive federal survey of record (F242 and F 287) showed a pattern of the facility inability to sustain an effective Quality Assurance (QAA) Program. The findings included: This citation was cross referenced to: 1. F 242-. Based on observations, staff interviews and record reviews the facility failed to honor Resident #167's choice to be served a Mechanical Soft sandwich at lunch and supper. This was evident in 1 of 4 residents in the sample reviewed for choices. During the recertification survey conducted October 29, 2015, the facility failed to allow residents to make bathing choices that were significant for 2 of 4 resident review for activities of daily living during 2. F 278 - Based on observations, record reviews, resident and staff interviews, and the facility failed to code the Minimum Data Set (MDS) assessment accurately for 1 of 3 residents reviewed for incontinence (Resident #112). The facility failed to accuracy code on the MDS the dental status for 1 of 3 residents reviewed for nutrition. (Resident #162) During the recertification survey conducted October 29, 2015, the facility failed to 1) accurately code on the Minimum Data Set (MDS) assessment to reflect Preadmission screening and resident review (PASARR) for 1 of 1 resident in the sample reviewed for PASRR and 2) failed to accurately code the admission MDS to reflect the administration to 1 of 5 residents reviewed for pneumococcal vaccinations. Interview with Quality Assurance (QA) Nurse on 10/13/2016 at 3:30PM revealed the facility will	F 520	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 11/9/2016. For the residents affected: In reference to F242, in-servicing all dietary staff of the importance of completing meal trays accurately according to the tray card. Auditing of the tray lines at meal time have also been put in place to ensure trays are accurate and complete when they are sent out of the kitchen. In reference to F278, both MDS coordinators were in-serviced on investigating any coding outliers when they do not seem to be in accordance with the resident's current functional ability. If errors are found, they are to make corrections accordingly in order to complete an accurate MDS assessment. The in-service also covered the importance of assessing the resident in person rather than solely relying on documentation during the lookback period. All CNA's were also in-serviced on the importance of coding as accurately as possible in order to portray an accurate picture of	

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F 520	Continued From page 17 continue to implement and monitor concerns and issues with repeat and new citation. Continued interview with the QA nurse indicated the QAA committee currently uses the Quality Assurance and Performance Improvement (QAPI) concept and the team will meet monthly to maintain procedures and monitor interventions that the committee had put in place. Further interview with the QA Nurse revealed that QAPI meeting was scheduled to meet after this survey.	F 520	each resident. For the residents with the potential to be affected/Measures put in place: Audits were put in place to ensure compliance with F242 &F278. In reference to F242, a new certified Dietary Manager was hired on 10/24/2016 to manage the Dietary Department & ensure compliance with regulations. In addition, a more detailed, audit-driven Quality Assurance Performance Improvement Program has recently been adopted by the facility. This new program will improve the overall quality of care for all residents. The first QAPI meeting is to be held on November 9th, 2016. Monitoring: These plans of correction will be followed and discussed in the QAPI committee meeting. Any areas of concerns will be addressed immediately amongst the appropriate committee members and process changes will be made as needed.	