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 _____	05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 resident and staff interview, the facility failed to accommodate resident's need for a grab bar in bed per the side rail assessment for 1 of 1 sampled resident reviewed (Resident #6). 1. Resident #6 was admitted to the facility on 5/30/09 with multiple diagnoses including Multiple Sclerosis. The annual Minimum Data Set (MDS) assessment dated 2/21/18 indicated that Resident #6's cognition was intact and she needed extensive assistance with bed mobility. On 4/4/17, Resident #6 was assessed for the use of the side rail. The assessment form revealed that Resident #6 was using the side rail for positioning or support and she had expressed a desire to have the side rails raised in bed for safety and or comfort. The side rails were indicated to serve as enabler to promote independence and the resident had expressed a desire to have the side rails while in bed. On 5/22/18 at 9:30 AM, Resident #6 was observed in bed. She had a grab bar on the left side of bed and a bed side table on the right side of bed. She stated that she had requested to have a grab bar on the right side of her bed to help her turned to her right side during care.	F 558	F558 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 May 21st, 2018 survey and does not constitute an agreement or admission of Clapp's Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 06/15/2018. Key members of the Quality Assurance Performance Improvement committee met to determine the root cause of the citation related to F558 as well as a plan to correct the citation. The key Members	6/15/18

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

Electronically Signed | 06/11/2018

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F 558	Continued From page 1 Resident #6 stated that she had to grab on the night stand to turn to her right side and she didn't feel safe and comfortable. She added that she had requested for the grab bar several times but she was told that the state didn't want the side rails in beds. On 5/22/18 at 1:47 PM, the Nursing Aide (NA) # 7 was interviewed. NA #7 was assigned to Resident #6. She stated that Resident #6 needed help with turning but she could hold on to the rail when turned during care and she felt safe when the side rail was up in bed. On 5/22/18 at 2:12 PM, the Director of Nursing (DON) was interviewed. She stated that she was aware that Resident #6 had requested to have a side rail in bed for safety reasons but she had informed the resident that she could not have a side rail in bed due to entrapment issue and the resident was not happy about it. The DON added that Resident #6 was not assessed for the need of the side rail when it was removed from her bed. On 5/24/18 at 10:10 AM, the Administrator was interviewed. She stated that she agreed that a side rail assessment should have been completed prior to removing the side rails from the resident's beds.	F 558	included the Administrator, Director of Nursing and MDS Coordinators. The Committee determined there had been a misunderstanding among previously employed facility management related to the new side rail regulations. The facility had, and always will have, the full intent to abide by all regulations and honor resident's rights, while also attempting to keep residents safe while in our care. For Resident #6, a side rail assessment was completed on 06/12/2018 by the Unit Manager and was assessed to be safe using the left side rail only. The results of the side rail assessments were reviewed with Resident #6 on 06/12/2018. In order to be in substantial compliance with F558, all Nurses and CNAs from all shifts as well as all facility managers were in-serviced by the Director of Nursing on the correct intent of the new regulations made by the state, including the fact that all residents have the right to be assessed for side rails. This in-service was complete on 06/08/2018. The facility will also complete side rail assessments on all current residents. These assessments will be completed collaboratively by the Therapy Department and the Nurse Managers by 06/13/2018. A review of the side rail assessment and the results of this assessment will also be reviewed with resident/responsible party, whichever applicable. All long-term residents will be re-assessed for side rails quarterly and as needed if the resident's condition changes by the Minimal Data Set Coordinator. All new admissions will have a side rail assessment completed by a Therapist	

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F 558	Continued From page 2	F 558	upon admission to the facility. All Nurse Managers and Therapists were in-serviced by the Director of Nursing on this new protocol by 06/08/2018. In order to ensure the facility's solutions are sustained and that substantial compliance with F558 continues, 5 residents will be randomly chosen by the Director of Nursing or Administrator per week x 5 weeks. These 5 resident's medical records will be audited to ensure a side rail assessment has been completed and documentation is noted within the record stating the resident/responsible party has been educated on our side rail assessment protocol and the results of this assessment. If the resident is newly admitted, the Director of Nursing or Administrator is to ensure the side rail assessment was completed by a therapist upon admission. If substantial compliance is found during this audit, the audit will be reduced to 5 residents per month x 3 months. If substantial compliance is found during the monthly audits, the audit will then be discontinued. This audit will be followed by the Quality Assurance Performance Improvement Committee and discussed in the bi-weekly/monthly QAPI meetings. The Director of Nursing is responsible for presenting the plan of correction to the QAPI committee. Any areas of concern found will be addressed upon discovery by the appropriate committee members.	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		6/15/18

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F 561	Continued From page 3 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to honor residents' choices by removing side rails for cognitively intact residents who expressed a desire to have side rails for 4 of 4 residents reviewed for choices (Residents #10, #12, #15, and #37).	F 561	F561 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 May 21st, 2018 survey and does	

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F 561	Continued From page 4 The findings included: 1. Resident #15 was admitted to the facility on 9/30/16 with multiple diagnoses that included Parkinson ' s Disease. The quarterly Minimum Data Set (MDS) assessment dated 3/11/18 indicated Resident #15 ' s cognition was intact. She was assessed as requiring the limited assistance of 1 staff for bed mobility and transfers. She had no impairment with range of motion. The plan of care for Resident #15, dated 3/11/18, included a self-care deficit requiring the limited assistance of staff with bed mobility and with transfers at times. An interview was conducted with Resident #15 during the Resident Council Meeting held on 5/22/18 beginning at 2:00 PM. She indicated a concern about the removal of her side rails. She stated her side rails had been removed several months ago despite her expressed desire to have side rails on her bed to assist with positioning. Resident #15 indicated when her side rails were removed the staff had not addressed her desire to keep the side rails and they also had not discussed with her the risks and benefits of side rail usage. An interview was conducted with the Director of Nursing (DON) on 5/22/18 at 10:52 AM. The DON stated that at the beginning of 2017 most residents in the facility had side rails. She stated that the facility gradually began removing side rails to reduce their usage between March 2017 and October 2017. She reported that side rail assessments should have been completed prior	F 561	not constitute an agreement or admission of Clapp's Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 06/15/2018. Key members of the QAPI committee met to determine the root cause of the citation related to F561 as well as a plan to correct the citation. The Committee determined there had been a misunderstanding among previously employed facility management related to the new side rail regulations. The facility had, and always will have, the full intent to abide by all regulations and honor resident's rights, while also attempting to keep residents safe while in our care. For Resident #10, #12, #15 and #37, side rail assessments were completed on or prior to 06/12/2018 by the Unit Manager or Therapist. The results of the side rail assessments were reviewed with each resident or responsible party on 06/12/2018. In order to be in substantial compliance with F558, all Nurses and CNAs from all shifts as well as all facility managers were in-serviced by the Director of Nursing on the correct intent of	

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F 561	Continued From page 5 to the removal of the side rails to determine the need for the side rails, to provide education on the risks and benefits of side rails, and to provide an alternative intervention if deemed necessary. The DON revealed side rail assessments had not been completed for all residents who had their side rails removed. She stated she reviewed Resident #15 ' s medical record and the most recent side rail assessment completed was dated 3/31/17. She reported this assessment indicated Resident #15 expressed a desire to have side rails raised while in bed. This assessment additionally indicated the recommendation was for bilateral side rails to serve as an enabler to promote independence. The DON confirmed the side rails for Resident #15 had been removed, no side rail assessment was completed prior to their removal, no education on the risks and benefits of side rail usage was provided to the resident, and no alternative intervention was implemented. An interview was conducted with the Administrator on 5/24/18 at 10:10 AM. The Administrator stated that side rail assessments should have been completed prior to the removal of the side rails. 2. Resident #10 was admitted to the facility on 1/5/17 with diagnoses that included cerebral atherosclerosis, Diabetes Mellitus, and restless leg syndrome. The quarterly Minimum Data Set (MDS) assessment dated 2/27/18 indicated Resident #10 ' s cognition was fully intact. He required the extensive assistance of 2 or more staff with bed mobility and transfers. He had no impairment with range of motion.	F 561	the new regulations made by the state, including the fact that all residents have the right to be assessed for side rails. This in-service was complete on 06/08/2018. The facility will also complete side rail assessments on all current residents. These assessments will be completed collaboratively by the Therapy Department and the Nurse Managers by 06/13/2018. A review of the side rail assessment and the results of this assessment will also be reviewed with resident/responsible party, whichever applicable. All long-term residents will be re-assessed for side rails quarterly and as needed if the resident's condition changes by the Minimal Data Set Coordinator. All new admissions will have a side rail assessment completed by a Therapist upon admission to the facility. All Nurse Managers and Therapists were in-serviced by the Director of Nursing on this new protocol by 06/08/2018. In order to ensure the facility's solutions are sustained and that substantial compliance with F561 continues, 5 residents will be randomly chosen by the Director of Nursing or Administrator per week x 5 weeks. These 5 resident's medical records will be audited to ensure a side rail assessment has been completed and documentation is noted within the record stating the resident/responsible party has been educated on our side rail assessment protocol and the results of this assessment. If the resident is newly admitted, the Director of Nursing or Administrator is to ensure the side rail assessment was completed by a therapist	

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F 561	Continued From page 6 The plan of care for Resident #10, dated 2/28/18, included a self-care deficit requiring the extensive assistance of 1-2 staff with bed mobility and transfers. An interview was conducted with Resident #10 during the Resident Council Meeting held on 5/22/18 beginning at 2:00 PM. He indicated a concern about the removal of his side rails. He stated his side rails had been removed several months ago despite his expressed desire to have side rails on his bed. Resident #10 indicated when his side rails were removed the staff had not addressed his desire to keep the side rails and they also had not discussed with him the risks and benefits of side rail usage. An interview was conducted with the Director of Nursing (DON) on 5/22/18 at 10:52 AM. The DON stated that at the beginning of 2017 most residents in the facility had side rails. She stated that the facility gradually began removing side rails to reduce their usage between March 2017 and October 2017. She reported that side rail assessments should have been completed prior to the removal of the side rails to determine the need for the side rails, to provide education on the risks and benefits of side rails, and to provide an alternative intervention if deemed necessary. She stated she reviewed Resident #10 ' s medical record and the most recent side rail assessment completed was dated 4/3/17. She reported this assessment indicated Resident #10 expressed a desire to have side rails raised while in bed. This assessment additionally indicated the recommendation was for side rails to serve as an enabler to promote independence. The DON confirmed the side rails for Resident #10 had been removed, no side rail assessment was	F 561	upon admission. If substantial compliance is found during this audit, the audit will be reduced to 5 residents per month x 3 months. If substantial compliance is found during the monthly audits, the audit will then be discontinued. This audit will be followed by the Quality Assurance Performance Improvement Committee and discussed in the bi-weekly/monthly QAPI meetings. The Director of Nursing is responsible for presenting the plan of correction to the QAPI committee. Any areas of concern found will be addressed upon discovery by the appropriate committee members.	

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F 561	Continued From page 7	F 561		

completed prior to their removal, no education on the risks and benefits of side rail usage was provided to the resident, and no alternative intervention was implemented.

An interview was conducted with the Administrator on 5/24/18 at 10:10 AM. The Administrator stated that side rail assessments should have been completed prior to the removal of the side rails.

3. Resident #12 was admitted to the facility on 1/19/16 with diagnoses that included osteoporosis, adult failure to thrive, weakness, and age-related debility.

The quarterly Minimum Data Set (MDS) assessment dated 2/28/18 indicated Resident #12 ' s cognition was fully intact. She required the extensive assistance of 2 or more staff with bed mobility and 1 staff with transfers. She had no impairment with range of motion.

The plan of care for Resident #12, dated 2/28/18, included a self-care deficit requiring the extensive assistance of staff with bed mobility and transfers.

An interview was conducted with Resident #12 during the Resident Council Meeting held on 5/22/18 beginning at 2:00 PM. She indicated a concern about the removal of her side rails. She stated her side rails had been removed several months ago despite her expressed desire to have side rails on her bed. Resident #12 indicated when her side rails were removed the staff had not addressed her desire to keep the side rails and they also had not discussed with her the risks and benefits of side rail usage.

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An interview was conducted with the Director of Nursing (DON) on 5/22/18 at 10:52 AM. The DON stated that at the beginning of 2017 most residents in the facility had side rails. She stated that the facility gradually began removing side rails to reduce their usage between March 2017 and October 2017. She reported that side rail assessments should have been completed prior to the removal of the side rails to determine the need for the side rails, to provide education on the risks and benefits of side rails, and to provide an alternative intervention if deemed necessary. She stated she reviewed Resident #12 ' s medical record and the most recent side rail assessment completed was dated 3/31/17. She reported this assessment indicated Resident #12 expressed a desire to have side rails raised while in bed. The assessment additionally indicated the recommendation was for bilateral side rails to serve as an enabler to promote independence and to address the medical conditions/symptoms of osteoporosis and weakness. The DON confirmed the side rails for Resident #12 had been removed, no side rail assessment was completed prior to their removal, no education on the risks and benefits of side rail usage was provided to the resident, and no alternative intervention was implemented.

An interview was conducted with the Administrator on 5/24/18 at 10:10 AM. The Administrator stated that side rail assessments should have been completed prior to the removal of the side rails.

4. Resident #37 was admitted to the facility on 3/30/17 and most recently readmitted on 1/28/18 with diagnoses that included Traumatic Brain Injury (TBI) and hemiplegia (paralysis of one side

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F 561	Continued From page 9	F 561		

of the body) affecting the left dominant side.

The annual Minimum Data Set (MDS) assessment dated 4/3/18 indicated Resident #37 ' s cognition was intact. He required the extensive assistance of 2 or more staff for bed mobility and was dependent on 2 or more staff for transfers. He had impairment on both sides of his upper and lower extremities.

The plan of care for Resident #37, dated 4/3/18, included a self-care deficit requiring the extensive to total assistance of staff with personal care and mobility.

An interview was conducted with Resident #37 during the Resident Council Meeting held on 5/22/18 beginning at 2:00 PM. He indicated a concern about the removal of his side rails. He stated his side rails had been removed several months ago despite his expressed desire to have side rails on his bed. Resident #37 indicated when his side rails were removed the staff had not addressed his desire to keep the side rails and they also had not discussed with him the risks and benefits of side rail usage.

An interview was conducted with the Director of Nursing (DON) on 5/22/18 at 10:52 AM. The DON stated that at the beginning of 2017 most residents in the facility had side rails. She stated that the facility gradually began removing side rails to reduce their usage between March 2017 and October 2017. She reported that side rail assessments should have been completed prior to the removal of the side rails to determine the need for the side rails, to provide education on the risks and benefits of side rails, and to provide an alternative intervention if deemed necessary.

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F 561	Continued From page 10 She stated she reviewed Resident #37 ' s medical record and the most recent side rail assessment completed was dated 3/31/17. She reported this assessment indicated Resident #37 expressed a desire to have side rails raised while in bed. The assessment additionally indicated the recommendations were for bilateral side rails to serve as an enabler to promote independence and to address the medical conditions/symptoms of TBI. The DON confirmed the side rails for Resident #37 had been removed, no side rail assessment was completed prior to their removal, no education on the risks and benefits of side rail usage was provided to the resident, and no alternative intervention was implemented. An interview was conducted with the Administrator on 5/24/18 at 10:10 AM. The Administrator stated that side rail assessments should have been completed prior to the removal of the side rails.	F 561		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written	F 565		6/15/18

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requests that result from group meetings.
(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.
(A) The facility must be able to demonstrate their response and rationale for such response.
(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on review of the resident council meeting minutes, record review, and interviews with residents and staff, the facility failed to document and respond to concerns for 5 of 10 sampled residents who regularly attended resident council meetings (Residents #6, #10, #12, #15, and #37).

The findings included:

1. A resident council meeting was conducted on 5/22/18 at 2:00 PM. This meeting revealed an issue with documentation and resolution of concerns reported during the resident council meetings. Multiple group members reported a shared concern that had been discussed in resident council meetings that had not been addressed by facility staff. This concern was

F565

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 May 21st, 2018 survey and does not constitute an agreement or admission of Clapp's Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period

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F 565	Continued From page 12 regarding the removal of their side rails that occurred in the fall of 2017. The residents stated they brought up this concern during more than one resident council meeting, all unable to recall the specific months this was brought up, and were provided with no follow up and/or resolution. A review was conducted of the resident council meeting minutes dated 11/1/17, 12/6/17, 1/3/18, 2/7/18, 3/7/18, 4/4/18, and 5/2/18. There was no mention of any concerns related to side rails in the resident council meeting minutes. 1a. Resident #15 was identified as alert and oriented and the president of the resident council. The quarterly Minimum Data Set assessment dated 3/11/18 indicated Resident #15 ' s cognition was intact. A review of the resident council minutes indicated Resident #15 had attended 7 of the last 7 resident council meetings. During the resident council meeting on 5/22/18 at 2:00 PM Resident #15 indicated she had reported her concern with the removal of her side rails during more than one resident council meeting and was provided with no follow up and/or resolution. 1b. Resident #12 was identified as alert and oriented and a regular attendee of the resident council. The quarterly Minimum Data Set assessment dated 2/28/18 indicated Resident #12 ' s cognition was intact. A review of the resident council minutes indicated Resident #12 had attended 7 of the last 7 resident council meetings.	F 565	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 06/15/2018. Key members of the QAPI committee met to determine the root cause of the citation related to F565 as well as a plan to correct the citation. The Committee determined there had been a misunderstanding among previously employed facility management related to the new side rail regulations. Due to this, the Social Worker was under the impression there was no action that could be taken related to the concerns voiced by 5 of the 10 sampled residents. For the five residents affected, Resident #6, #10, #12, #15 and #37, a formal grievance was written on 06/08/2018 for each resident and the facility's grievance procedure was followed accordingly by the Social Worker. In order to achieve substantial compliance with F565, the Social Worker, along with all other Managers, all RNs, all LPNs and all Therapists were in-serviced by the Director of Nursing on the correct intent of the new regulations made by the state, including the fact that all residents have the right to be assessed for side rails. This in-service was completed by 06/08/2018. The Social Worker was also educated by the Director of Nursing on 06/05/2018 related to the requirement of following the facility's grievance policy and procedure no matter what the concern	

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F 565	Continued From page 13 During the resident council meeting on 5/22/18 at 2:00 PM Resident #12 indicated she had reported her concern with the removal of her side rails during more than one resident council meeting and was provided with no follow up and/or resolution. 1c. Resident #6 was identified as alert and oriented and a regular attendee of the resident council. The quarterly Minimum Data Set assessment dated 5/18/18 indicated Resident #6 ' s cognition was intact. A review of the resident council minutes indicated Resident #6 had attended 4 of the last 7 resident council meetings. During the resident council meeting on 5/22/18 at 2:00 PM Resident #6 indicated she had reported her concern with the removal of her side rails during more than one resident council meeting and was provided with no follow up and/or resolution. 1d. Resident #37 was identified as alert and oriented and a regular attendee of the resident council. The annual Minimum Data Set assessment dated 4/3/18 indicated Resident #37 ' s cognition was intact. A review of the resident council minutes indicated Resident #37 had attended 5 of the last 7 resident council meetings. During the resident council meeting on 5/22/18 at 2:00 PM Resident #37 indicated he had reported his concern with the removal of his side rails during more than one resident council meeting	F 565	voiced by the resident may be. To ensure substantial compliance with F565 continues, the DON or Administrator will ask to be invited to the monthly resident council meeting for the next 3 months. Permitting the residents allow the DON or designee to participate in the meetings, the DON or designee will observe the meeting and note any concerns voiced. Within 24 hours of the resident council meeting, the DON or Administrator will review the meeting minutes and the facility grievances to ensure all concerns observed were noted on the meeting minutes and that all concerns are being actively addressed, per the facility's grievance policy and procedure. If substantial compliance is found after the monthly audit, the DON or Administrator will then ask to be invited to one meeting per quarter for 1 year to ensure on-going compliance. If substantial compliance is found after participating in the meeting one quarter out of the year, the audit will be discontinued. This citation and the plan of correction will be followed by the facility's QAPI Committee and results of this audit will be discussed in the bi-weekly/monthly meetings and as needed. The Director of Nursing is responsible for presenting this plan of correction to the QAPI committee. Any areas of concern will be addressed immediately with the committee's appropriate members.	

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F 565	Continued From page 14	F 565		

and was provided with no follow up and/or resolution.

1e. Resident #10 was identified as alert and oriented and a regular attendee of the resident council. The quarterly Minimum Data Set assessment dated 2/27/18 indicated Resident #10 ' s cognition was intact.

A review of the resident council minutes indicated Resident #10 had attended 4 of the last 7 resident council meetings.

During the resident council meeting on 5/22/18 at 2:00 PM Resident #10 indicated he had reported his concern with the removal of his side rails during more than one resident council meeting and was provided with no follow up and/or resolution.

An interview was conducted with the Social Worker (SW) on 5/22/18 at 4:20 PM. She indicated she was responsible for coordinating the resident council meetings, attending the meetings, ensuring the minutes for the meetings were documented, and that concerns reported during the meetings were followed up on. She stated she was aware of at least of one of the members of the resident council (Resident #6) bringing up a concern regarding the removal of side rails on more than one occasion. She revealed she had not written this down in the minutes and had not followed up on the concern. The SW explained that she was informed side rails were not allowed to be utilized in the facility so she thought nothing could be done about it.

An interview was conducted with the Director of Nursing on 5/23/18 at 10:52 AM. She stated that

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F 565	Continued From page 15 most of the residents in the facility had their side rails removed several months ago in an effort to decrease side rail usage. She reported she was aware of some residents having concerns regarding the removal of side rails, but was unaware this concern had been discussed in the resident council. She indicated she expected the resident council minutes to accurately reflect the residents ' discussions and concerns and for the concerns to be followed up on.	F 565		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility neglected to implement a care plan intervention related to falls that indicated Resident #28 was not to be left alone in the bathroom when she was assisted with toileting. Resident #28 was assisted to the bathroom by Nursing Assistant (NA) #1, NA #1 exited the bathroom to retrieve items from the	F 600	F600 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 May 21, 2018 survey and does not	6/15/18

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F 600	Continued From page 16 resident ' s room, and Resident #28 fell as she attempted to transfer independently from the toilet to her wheelchair while unattended by staff. The fall resulted in Resident #28 sustaining a subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain) and a subdural hematoma (pool of blood between the brain and its outermost covering). This was for 1 of 1 residents reviewed for neglect. The findings included: Resident #28 was admitted to the facility on 11/21/17 and readmitted on 1/5/18 with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), adult failure to thrive, age related debility, weakness, and difficulty in walking. The admission Minimum Data Set (MDS) assessment dated 1/12/18 indicated Resident #28 ' s cognition was fully intact. She had no behaviors and no rejection of care. Resident #28 required the extensive assistance of 2 or more staff with bed mobility and the extensive assistance of 1 staff for toileting, dressing, and personal hygiene. She required the limited assistance of 1 staff for transfers. Resident #28 was not steady on her feet, but she was able to stabilize without staff assistance. She utilized a wheelchair and walker and had no impairment with her range of motion. Resident #28 was frequently incontinent of bladder and bowel. The Care Area Assessment (CAA) related to Activities of Daily Living (ADLs) for Resident #28 ' s 1/12/18 MDS indicated she required limited to extensive assistance of 1 staff with ADLs related to a debilitated state, weakness, and balance	F 600	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 06/15/2018. Key members of the QAPI committee met to determine the root cause of the citation related to F600. The committee determined the care plan for Resident #28 inaccurately addressed the resident's needs at the time of the fall. The committee also determined that tasks, such as fall interventions, which the CNAs are responsible for were not being layered in the care plan in such a way that the CNAs were able to see the tasks on their kiosks. To minimize risk of Resident #28 having further accidents, the care plan was updated correctly so that the CNA's tasks and responsibilities, including fall interventions, would show up in the task care plan for the CNA's to see. Being able to view this information allows the CNA's to know specifically the assistance resident needs during toileting tasks. Specific interventions which have been implemented since resident's first fall on	

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F 600	Continued From page 17 problems. The CAA related to falls for Resident #28 ' s 1/12/18 MDS indicated she was at risk for falls with injury. Resident #28 ' s plan of care included the focus area of the potential for falls. This area was initiated on 11/28/17 and reviewed on 1/12/18. The interventions included, in part, "Staff to monitor me during toileting task if assisted to bathroom ...transfer back to chair/bed. Do not leave me alone in bathroom." A review was conducted of the NA documentation for Resident #28 ' s toileting task from 2/1/18 through 3/1/18. The NA documentation indicated Resident #28 ' s level of required assistance for toileting varied from the limited assistance of 1 staff to total dependence of 2 or more staff. An incident report dated 3/1/18 and written by Nurse #1 indicated Resident #28 had an unwitnessed fall with injury on 3/1/18 at 8:15 AM. Resident #28 ' s injuries were noted as, "skin tear - superficial, bruise/redness, hematoma". Nurse #1 was called to Resident #28 ' s bathroom by staff. Resident #28 had fallen from the toilet onto the floor as she was attempting to transfer into her wheelchair. Resident #28 was noted to have two skin tears, one to the left elbow and one to the left knee. Both skin tears were cleaned and dressed. An ice pack was applied to Resident #28 ' s head. She was assisted back to her wheelchair by 2 staff. The physician and Responsible Party (RP) were contacted. The Fall Scene Investigation (FSI) Report related to Resident #28 ' s fall on 3/1/18 at 8:15 AM indicated NA #1 was the first staff present following Resident #28 ' s unwitnessed fall.	F 600	03/01/2018 and to minimize risk of falls include: Resident given non-skid socks and educated on the importance of wearing them and education provided on not attempted to transfer from any surface without assistance. The Task Care plan was updated on 05/23/2018 to reflect all appropriate fall interventions for Resident #28. All current charts of residents with fall interventions in place were audited by the MDS Consultants prior to 06/15/2018 to ensure the interventions which CNAs were responsible for were both accurate and viewable by the CNA. Also prior to 06/15/2018, the Director of Nursing and MDS Coordinator completed a full audit of all physical fall interventions and verified the physical interventions were in place. The facility has now initiated a new process for entering CNA tasks into the care plan in order for the CNA to be able to see their required tasks/duties. All nurses and CNAs will be re-educated on where to view the task care plan by 06/15/2018 by DON or Unit Manager. They were also educated that interventions in which CNAs are responsible for will be viewable on the task care plan so the CNA can view the care planned interventions every shift. The facility has created a QAPI audit for monitoring the fall interventions listed on the resident's care plan, task care plan, and are being followed as written. Due to the citation and in order to ensure compliance on-going, 5 Care Plans will be audited per week x 4 weeks by the Director of Nursing to ensure proper fall	

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F 600	Continued From page 18 Resident #28 was found on the floor in her bathroom after attempting to self-transfer. Resident #28 was assessed as alert and oriented prior to the fall. She stated she was trying to transfer to her wheelchair. The FSI Report provided a written statement from NA #1. NA #1 indicated Resident #28 pressed her call light on 3/1/18 around 7:50 AM. NA #1 answered the call light and proceeded to assist Resident #28 with her bathing and dressing. She then assisted Resident #28 to her bathroom (located inside of Resident #28 ' s bedroom). NA #1 reported that after she had transferred Resident #28 from her wheelchair to the toilet she had stepped out of the bathroom to pick-up the resident ' s nightgown and linens from the floor in her room. NA #1 indicated while she was outside of the bathroom she heard Resident #28 scream. She noted that Resident #28 had not called out verbally for her assistance and she had not rang the call bell. NA #1 indicated she reminded Resident #28 to use the call light for assistance in the bathroom. A nursing note dated 3/1/18 and written by Nurse #1 confirmed the information in the incident report dated 3/1/18. The note additionally indicated Resident #28 had bumped her head on the floor and neurological assessments were initiated. A physician ' s order dated 3/1/18 indicated neurological assessments for Resident #28. A review was conducted of the neurological assessments dated 3/1/18 beginning at 8:30 AM. These assessments indicated no concerns with Resident #28 ' s condition through the assessment completed on 3/1/18 at 11:30 AM. A nursing note dated 3/1/18 at 12:02 PM	F 600	interventions are listed on the resident's care plan, task care plan, and any physical interventions are in place. If substantial compliance is found, the audit will be reduced to 2 Care Plans per month x 3 months. Once the audits are complete the QAPI committee will review the audits and determine the frequency of the audits going forward. Also to ensure on-going compliance, the unit managers or director of nursing will observe 5 CNA's per week for 4 weeks during one toileting task to ensure care planned interventions are being followed by CNA. If substantial compliance is found during the weekly audit, the audit will then be reduced to 5 CNAs monthly for 3 months. These audits will be completed on all shifts as well as on weekends. If substantial compliance continues to be found during the monthly audit, spot checks will continue by unit managers on an on-going basis. The QAPI committee will discuss the progress and results of this Plan of Correction in the bi-weekly/monthly meetings and more often if needed. The Director of Nursing will be responsible for presenting this plan of correction to the QAPI committee. Any areas of concern will be addressed accordingly by the appropriate committee members.	

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indicated Nurse #1 was called to Resident #28 ' s room. Resident #28 had vomited and was shaking. She stated her head hurt and she didn ' t feel good. The physician was notified and an order was received to send Resident #28 to the Emergency Room (ER) for evaluation.

The ER records indicated Resident #28 was seen in the Emergency Department on 3/1/18 and a neurology consultation was ordered. The neurology consultation indicated Resident #28 presented with a traumatic Subarachnoid Hemorrhage (SAH) on the right side. A head CT (computerized tomography) scan showed suspected Subdural Hematoma (SDH). She was admitted to the hospital for repeat CT head scans and monitoring. This consultation noted that it was discussed whether Resident #28 was more appropriate on neurology service or medicine service, but medicine service had not felt comfortable managing the size of Resident #28 ' s bleed. The hospital records indicated Resident #28 remained in the hospital from 3/1/18 through 3/5/18 when she was discharged back to the facility.

Resident #28 ' s plan of care related to falls was updated on 3/5/18 with the handwritten intervention, "Do not leave Resident alone in bathroom." This was a duplicate intervention as it was previously in place on the care plan.

A physician ' s progress note dated 3/28/18 indicated Resident #28 was readmitted to the facility following a hospital stay for a fall resulting in closed head trauma, SAH, and SDH. Repeated head CTs at the hospital showed stability.

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A review of the medical record indicated Resident #28 has returned to her baseline health status.

The NA Daily Care Guide, undated, for Resident #28 was reviewed on 5/22/18. The interventions for Resident #28 included, in part, "Staff to monitor me during toileting task if assisted to bathroom ...transfer back to chair/bed. Do not leave me alone in bathroom."

An interview was conducted with the DON on 5/22/18 at 3:05 PM. The DON stated that the interventions on the care plan were linked to the NA Daily Care Guide interventions. She stated if the intervention was in place on the care plan, then it was also in place on the NA Daily Care Guide. The intervention for Resident #28 that indicated, "Staff to monitor me during toileting task if assisted to bathroom ...transfer back to chair/bed. Do not leave me alone in bathroom" was reviewed with the DON. She confirmed this intervention was in place on the care plan and on the NA Daily Care Guide at the time of Resident #28 ' s 3/1/18 fall.

An interview was conducted with NA #1 on 5/22/18 at 2:25 PM. She stated she had worked at the facility for about 3 years and she was familiar with Resident #28. She reported Resident #28 was a fall risk and she had several falls. She confirmed she was working with Resident #28 on 3/1/18 at the time of her 8:15 AM fall. She stated she had taken Resident #28 to the bathroom after she assisted her with bathing. NA #1 indicated she transferred Resident #28 to the toilet, she stayed in the bathroom during the task of toileting, and she changed Resident #28 ' s brief. She reported prior to transferring Resident #28 off of the toilet

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and back to her wheelchair, she left the bathroom to retrieve a roll of trash bags she had left in Resident #28 ' s room. She indicated she was out of the bathroom for about 5 seconds when she heard Resident #28 scream, she re-entered the bathroom, and she found her on the floor. NA #1 confirmed that Resident #28 had fallen while attempting to self-transfer without staff present.

This interview with NA #1 continued. She was asked how she was made aware of fall risk interventions that were in place. She stated the NA kiosk, an electronic record of the NA Daily Care Guide, had a list of all of the interventions for each resident. The NA kiosk for Resident #28 was reviewed with NA #1. The kiosk included the intervention, "Staff to monitor me during toileting task if assisted to bathroom ...transfer back to chair/bed. Do not leave me alone in bathroom." NA #1 acknowledged she had assisted Resident #28 to the bathroom and left her alone while she retrieved items from the resident ' s room. She revealed she had not known this intervention was in place for Resident #28. She reported that she thought Resident #28 was able to toilet independently and that she only needed assistance changing her brief.

An interview was conducted with Nurse #1 on 5/23/18 at 9:06 AM. She stated she had worked at the facility for over 11 years and she was familiar with Resident #28. She reported Resident #28 was a fall risk and she had several falls. She confirmed she was working with Resident #28 on 3/1/18 at the time of her 8:15 AM fall. She indicated Resident #28 had lost her balance and fell off of the toilet onto her bathroom floor. She stated Resident #28 had a couple of skin tears and redness noted to her head. Nurse

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CLAPP'S CONVALESCENT NURSING HOME INC	500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203

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F 600	Continued From page 22 #1 reported she assessed Resident #28 ' s neurological status and noted no concerns with her condition. She obtained an order for neurological assessments from the physician and had completed the assessments with no noted changes in condition until Resident #28 presented with vomiting and shaking early that same afternoon (3/1/18). She indicated Resident #28 was then sent to the ER for evaluation and was admitted to the hospital. An interview was conducted with Resident #28 on 5/23/18 at 9:30 AM. She indicated she had fallen multiple times at the facility. She stated she needed help getting on and off the toilet and changing her brief after toileting. The 3/1/18 fall at 8:15 AM was discussed with Resident #28. She stated she was in the bathroom, the NA (NA #1) left the bathroom, and she tried to get up on her own. She reported she lost her balance and fell and hit her head on the bathroom floor. A follow up interview was conducted with the DON on 5/24/18 at 10:10 AM. She stated the purpose of care plan interventions related to falls were to reduce the risk for falls and to avoid preventable falls. She indicated she expected staff to be aware of care plan interventions and to implement them at all times.	F 600		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the	F 637		6/15/18

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F 637	Continued From page 23 resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after the resident was determined to have a significant change in health status for 1 of 4 sampled residents reviewed (Resident #29). Findings included: Resident #29 was originally admitted to the facility on 3/22/18 with multiple diagnoses including unspecified psychosis. The admission MDS assessment dated 3/28/18 indicated that Resident #29 did not have a pressure ulcer nor an indwelling urinary catheter. The assessment further indicated that Resident #29 did not have behaviors. The medical records revealed that Resident #29 was discharged to the hospital on 4/2/18 and was readmitted to the facility on 4/5/18. The 14 day MDS assessment dated 4/19/18 indicated that Resident #29 had an unstageable pressure ulcer and an indwelling urinary catheter. The assessment further indicated that Resident #29 had displayed verbal behaviors and rejection of care.	F 637	F637 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 May 21st, 2018 survey and does not constitute an agreement or admission of Clapp's Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 06/15/2018. Key members of the QAPI committee met to determine the root cause of the citation related to F637 as well as a plan to correct the citation. The Committee	

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F 637	Continued From page 24 On 5/23/18 at 1:50 PM, MDS Nurse #2 was interviewed. She reviewed the medical records of Resident #29 and stated that a significant change in status MDS should have been completed when Resident #29 was readmitted. She verified that Resident #29 was readmitted with pressure ulcer, indwelling urinary catheter and with behaviors. On 5/24/18 at 9:26 AM, the Director of Nursing (DON) was interviewed. She stated that she expected a significant change in status MDS assessment completed within 14 days after a resident had 2 or more changes noted.	F 637	determined the Significant Change assessment needed for resident #29 was due to the MDS Coordinator being insufficiently educated related to screening for significant change assessments. For the resident affected, a significant change assessment was completed by the MDS Coordinator on 05/25/2018. To achieve substantial compliance with F637, the MDS Coordinators will audit all records of residents who have discharges and returned to the facility in the last 3 months to ensure no other significant change assessments have been missed. If any significant change assessments are found, a correct assessment is to be completed immediately. All charts will be reviewed by 06/15/2018. The facility MDS coordinators were in-serviced by the Director of Nursing on 06/08/2018 related to reviewing all new Physician Orders weekly at minimum in order to catch clinical changes with residents which may possibly warrant a significant change assessment to be completed within 14 days. By pulling this report, the MDS Coordinators will be able to recognize any residents who have gone out to the hospital and returned with a change of condition and they will also be able to catch clinical changes with the residents within the facility who have not left. The MDS Coordinators were re-educated by the Director of Nursing on significant change assessment requirements per the Resident Assessment Instrument manual on 06/08/2018.	

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F 637	Continued From page 25	F 637	To ensure substantial compliance with F637 is sustained, the Director of Nursing will audit the MDS assessments for all residents who are sent out to the hospital and return weekly for 3 months to ensure a significant change is not warranted. If substantial compliance is found during the weekly audit, the audit will then be reduced to all residents who are sent out and return to facility per month, on-going. This citation and the plan of correction will be followed by the facility's QAPI Committee and results of this audit will be discussed in the bi-weekly/monthly meetings and as needed. The Director of Nursing is responsible for presenting this plan of correction to the QAPI committee. Any areas of concern will be addressed upon discovery with the committee's appropriate members.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of falls (Resident #28), pain management and skin infections (Resident #70), and active diagnoses (Resident #56) for 3 of 19 residents reviewed. The findings included: 1. Resident #28 was admitted to the facility on	F 641	F641 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 May 21st, 2018 survey and does not constitute an agreement or admission	6/15/18

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F 641	Continued From page 26 11/21/17 and most recently readmitted on 3/5/18 with multiple diagnoses that included subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain), subdural hematoma (pool of blood between the brain and its outermost covering), and a fall from one level to another. The medical record indicated Resident #28 had a fall with major injury on 3/1/18 in which the resident sustained a subarachnoid hemorrhage and a subdural hematoma. The quarterly Minimum Data Set (MDS) assessment dated 3/12/18 indicated Resident #28 ' s cognition was intact. Section J, the Health Conditions Section, indicated Resident #28 had 1 fall with major injury. The medical record indicated Resident #28 had no falls from 3/13/18 through 3/19/18. The 14-day MDS assessment dated 3/19/18 indicated Resident #28 ' s cognition was intact. Section J, the Health Conditions Section, indicated Resident #28 had 1 fall with major injury since the previous MDS assessment (3/12/18). An interview was conducted with MDS Nurse #1 on 5/23/18 at 11:30 AM. Section J of the MDS dated 3/19/18 for Resident #28 that indicated she had one fall with major injury since her previous MDS assessment (3/12/18) was reviewed with MDS Nurse #1. The medical record that indicated Resident #28 had no falls from 3/13/18 through 3/19/18 was reviewed with MDS Nurse #1. MDS Nurse #1 revealed she coded the 3/19/18 MDS incorrectly for Resident #28. She reported she should have coded the 3/19/18 MDS	F 641	of Clapp's Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 06/15/2018. Key members of the QAPI committee met to determine the root cause of the citation related to F641 as well as a plan to correct the citation. The Committee determined the MDS coordinator had not been sufficiently educated specifically related to coding in the falls, pain management, skin infections and diagnoses for 3 of 19 residents reviewed. As for the three residents with incorrect assessments, the MDS Coordinators submitted corrected MDS Assessments on 5/23/2018. The MDS Coordinator was re-educated related to the previously listed areas and the importance of coding accurately by the Director of Nursing on 06/06/2018. In addition, all residents' most current MDS will be reviewed by MDS Consultants prior to 06/15/2018 to ensure no other coding errors are found in the areas of falls, pain management, skin infections, and active diagnoses. Should any errors be found, a corrected MDS will	

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F 641	Continued From page 27 for Resident #28 as no falls because the 3/1/18 fall with major injury was captured on the 3/12/18 MDS. An interview was conducted with the Director of Nursing on 5/24/18 at 10:10 AM. She indicated she expected the MDS to be coded accurately. 2a. Resident #70 was admitted to the facility on 2/4/17 and most recently readmitted on 3/8/17 with multiple diagnoses that included heart failure. The quarterly Minimum Data Set (MDS) assessment dated 5/7/18 indicated Resident #70 ' s cognition was moderately impaired. She received opioid medication on 7 of 7 days. Section J, the Health Conditions Section, indicated Resident #70 had received no scheduled pain medications and no PRN pain medications during the 5-day pain management look back period (5/3/19 - 5/7/18). A review of Resident #70 ' s May 2018 physician ' s orders revealed the scheduled medications Tramadol (opioid pain medication) 50 milligrams (mg) 4 times daily and Tylenol 650 mg 4 times daily. The May 2018 physician ' s orders also included Oxycodone HCL (opioid pain medication) every 8 hours as needed (PRN). A review of Resident #70 ' s Medication Administrator Record (MAR) during the 5-day pain management look back period of the 5/7/18 MDS indicated she received scheduled Tramadol and Tylenol on 5 of 5 days and PRN Oxycodone on 3 of 5 days (5/3, 5/6, and 5/7/18).	F 641	be completed and submitted by the facility MDS Coordinators. To ensure substantial compliance with F641 is sustained, the Director of Nursing will audit ten completed assessments monthly for three months to ensure no errors were made in the areas of falls, pain management, skin infections, and active diagnoses. If substantial compliance is found during the monthly audit, the audit will then be reduced to 10 MDS Assessments quarterly for three quarters. If substantial compliance continues to be found, the audit will be discontinued. This citation and the plan of correction will be followed by the facility's QAPI Committee and results of this audit will be discussed in the bi-weekly/monthly meetings and as needed. The Director of Nursing will be responsible for presenting this plan of correction to the QAPI Committee. Any areas of concern will be addressed upon discovery with the committee's appropriate members.	

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F 641	Continued From page 28	F 641		

An interview was conducted with MDS Nurse #1 on 5/23/18 at 11:30 AM. Section J of the MDS dated 5/7/18 for Resident #70 that indicated she had received no scheduled pain medications and no PRN pain medications during the 5-day look back period was reviewed with MDS Nurse #1. The medical record that indicated Resident #70 had received scheduled pain medications on 5 of 5 days and PRN pain medications on 3 of 5 days during the 5-day look back period of the 5/7/18 MDS was reviewed with MDS Nurse #1. MDS Nurse #1 revealed she coded the 5/7/18 MDS incorrectly for Resident #70. She reported she should have indicated that Resident #70 had received scheduled pain medications and PRN pain medications on the 5/7/18 MDS. She stated she made an error.

An interview was conducted with the Director of Nursing on 5/24/18 at 10:10 AM. She indicated she expected the MDS to be coded accurately.

2b. Resident #70 was admitted to the facility on 2/4/17 and most recently readmitted on 3/8/17 with multiple diagnoses that included cellulitis of the toe.

A physician ' s order dated 4/27/18 for Resident #70 indicated Doxycycline Hyclate (antibiotic) 100 milligrams (mg) twice daily for ten days (stop date 5/6/18) related to a foot infection. A review of the Medication Administration Record (MAR) indicated Resident #70 received the antibiotic as ordered.

The quarterly Minimum Data Set (MDS) assessment dated 5/7/18 indicated Resident #70

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F 641	Continued From page 29	F 641		

' s cognition was moderately impaired. She was assessed with an active diagnosis of cellulitis of the toe and had received antibiotics on 6 of 7 days. Section M, the Skin Conditions Section, indicated Resident #70 had no foot infections.

An interview was conducted with MDS Nurse #1 on 5/23/18 at 11:30 AM. Section M of the MDS dated 5/7/18 for Resident #70 that indicated she had no foot infections was reviewed with MDS Nurse #1. The medical record that indicated Resident #70 had received antibiotics for a foot infection during the 5/7/18 MDS look back period was reviewed with MDS Nurse #1. MDS Nurse #1 revealed she coded the 5/7/18 MDS incorrectly for Resident #70. She reported she should have indicated that Resident #70 had a foot infection on Section M of the 5/7/18 MDS for Resident #70. She stated she made an error.

An interview was conducted with the Director of Nursing on 5/24/18 at 10:10 AM. She indicated she expected the MDS to be coded accurately.

3. Resident #56 was admitted to the facility on 7/28/17. Cumulative diagnoses included a diagnosis of diabetes and long-term use of insulin.

A quarterly Minimum Data Set (MDS) dated 4/24/18 indicated Resident #56 was severely impaired in cognition. Diagnoses documented as being active during the assessment period included long term (current) use of insulin. Medications administered during the seven-day assessment period indicated Resident #56 had not received any injections. Insulin injections and insulin orders for the past seven days was documented as "0".

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F 641	Continued From page 30 A review of physician orders for April 2018 and May 2018 revealed an order for metformin (oral diabetic medicine) 500 milligrams ½ tablet by mouth twice daily. There was not a physician ' s order for insulin. On 5/23/18 at 11:20 AM, an interview was conducted with the long- term care (LTC) MDS Coordinator who stated the diagnoses documented on the MDS assessment should include only active diagnoses and the long term (current) use of insulin should have not been included on Resident #56 ' s assessment. On 5/24/18 at 10:15 AM, an interview was conducted with the Director of Nursing who stated the MDS should be coded accurately for diagnosis.	F 641		
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	F 657		6/15/18

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F 657	Continued From page 31 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, Responsible Party (RP) and staff interviews and record review, the facility failed to revise resident care plans in the areas of pressure ulcers and pain for 3 (Resident #41, Resident #74 and Resident #6) of 19 resident care plans reviewed for revisions. The facility also failed to ensure all required participants were involved in the care planning process for 1 (Resident #36) of 1 residents reviewed for participation in the care planning process. The findings included: 1. Resident #41 was admitted on 11/21/14 with cumulative diagnoses of a left above the knee amputation (AKA), Peripheral Artery Disease (PAD) and Adult Failure to Thrive. The quarterly Minimum Data Set (MDS) dated 4/11/18 indicated severe cognitive impairment, no behaviors and total staff assistance for all her activities of daily living (ADLs). Resident #41 was coded for 2 unstageable pressure ulcers. Resident #41's care plan last revised on 4/11/18	F 657	F657 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 May 21st, 2018 survey and does not constitute an agreement or admission of Clapp's Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 06/15/2018.	

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F 657	Continued From page 32 indicated she had a potential for pressure ulcers due to her medical condition. She was care planned for one pressure ulcer to her right foot. Review of Resident #41's electronic and written medical record indicated she developed an unstageable pressure ulcer to her sacrum and a suspected deep tissue injury to her left buttock on 4/30/18. The Physician and her RP were notified and orders were given to treat both new areas. Observation of the right foot, left buttock and sacral pressure ulcers was completed on 5/22/18 at 11:42 AM. Nurse #2 stated the area to her buttock and her sacrum were newly developed. There were no observed concerns with the wound treatment regime or technique. Resident #41 was on a pressure reducing mattress and a cushion was observed in her wheelchair. Interview with Resident #41's RP was conducted on 5/22/18 at 12:00 PM. She stated that Resident #41 had issues with her remaining foot but the areas to her buttocks and sacrum were new. She stated the facility was treating her pressure ulcers and providing supplements to aid in healing but that Resident #41 was continuing to gradually decline. Interview with MDS Nurse #1 was conducted on 5/23/18 at 11:40 AM. She stated the actual pressure ulcers to Resident #41's left buttock and sacrum should have been care plan when they developed on 4/30/18. She stated she only became aware of one new area this week. She stated it was an oversight. During an interview on 5/24/18 at 10:17 AM, the Administrator and DON both indicated it was their	F 657	Key members of the QAPI committee met to determine the root cause of the citation related to F657 as well as a plan to correct the citation. The committee determined there was an oversight by the MDS Coordinator when revising the care plans for 3 of 19 residents in which further education needed to be completed. The committee also determined some facility employees had misinterpreted the Nurse Aide's role in the care planning process per the new care planning regulation. To achieve substantial compliance with F657, all individuals responsible for any part of the care planning process were educated on the new care planning regulations by the Director of Nursing on 06/08/2018. The individuals responsible for the care planning process include the Dietary Manager, MDS Coordinator, CNA, Social Worker and Activities Manager. All care plan committee members were educated on exactly which staff members are required to be a part of the care planning process, specifically related to the Nurse Aide's role in the care planning process. The care plans of resident #41, #74 and #6, were also updated by the MDS Coordinators to accurately reflect the resident's care needs specifically related to pressure ulcers and pain. MDS Consultants will audit all care plans of current residents by 06/15/2018 to ensure all care plans accurately address pressure ulcers or pain if applicable. The MDS coordinators were also educated by the Director of Nursing on 06/08/2018 related to timely updating the resident's care plan to accurately reflect the care needs of the	

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F 657	Continued From page 33 expectation that Resident #41's care plan would have been revised on 4/30/18 to reflect the actual development of the pressure ulcer to Resident #41's sacrum and left buttock. 2. Resident #74 was admitted on 2/24/18 with cumulative diagnoses of acute respiratory failure, pneumonia and dementia. Review of Resident #74's admission orders dated 2/24/18 did not include any medications for pain except for a standing order for Tylenol 650 milligrams (mg) every 6 hours as needed. Review of Resident #74's written physician orders indicated a new order for Neurontin (anti-epileptic medication used to treat nerve pain) 100 mg every night and scheduled Tylenol 650 mg every 6 hours were started on 3/2/18 for pain. Resident #74 was care planned for the potential for pain on 3/2/18. The care plan read she was prescribed Neurontin and Tylenol. Resident #74's admission Minimum Data Set (MDS) dated 3/3/18 indicated moderate cognitive impairments with no behaviors. She was coded as having no reported pain and ordered pain medication as needed. Review of Resident #74's written orders indicated she was prescribed Oxycodone (narcotic pain-reliever) 5 mg every 4 hours as needed for pain and her Neurontin was increased to 300 mg every night on 3/23/18. Review of a physician progress note dated 3/28/18 indicated Resident #74's chronic joint pain was controlled.	F 657	resident specifically related to pain and pressure ulcers. They were provided specific information related to the appropriate time to care plan “potential” for pain or pressure ulcer versus “actual” pain or pressure ulcer. In order to ensure on-going compliance with F657, the DON or Unit managers will participate in 5 care plan meetings per month for three months to ensure all required employees actively participates in the care plan meeting as required. If substantial compliance is found during the care plan meetings for the first three months, the audit will be reduced to 5 care plan meetings per quarter for three quarters. If substantial compliance continues to be found, the audit will be discontinued. Also to ensure on-going compliance with F657, the Director of Nursing will audit 20 care plans per month for 3 months to verify the care plan accurately reflects the care needs of the resident related to pressure ulcer and pain. If substantial compliance is found during these monthly audits, the audit will then be reduced to 20 care plans per quarter for three quarters. If substantial compliance continues to be found, the audit will be discontinued. This citation and the plan of correction will be followed in the facility’s QAPI Committee and results of this audit will be discussed in the bi-weekly/monthly meetings and as needed. The Director of Nursing is responsible for presenting this plan of correction to the QAPI committee. Any areas of concern will be addressed upon	

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F 657	Continued From page 34 Review of Resident #74's written orders indicated she was prescribed Tramadol (a synthetic opioid used to treat pain) 50 mg every 6 hours as needed for pain on 4/26/18. Interview was conducted with Resident #74's private sitter on 5/21/18 at 3:21 PM. She stated Resident #74's suffered from chronic pain due to a fall with injury some years ago. The private sitter and Resident #74 reported her pain was under control with the new medications ordered since her admission. Interview with the MDS Nurse #1 was conducted on 5/23/18 at 11:40 AM. She stated actual pain should have been care planned on 3/2/18 and her care plan should have been revised to include the new orders for the Oxycodone and Tramadol. She stated it was an oversight. During an interview on 5/24/18 at 10:17 AM, the Administrator and Director of Nursing both indicated it was their expectation that Resident #74's care plan would have been revised on 3/23/18 for actual pain and the Oxycodone. Both stated the care plan should have again been revised on 4/26/18 when the Tramadol was ordered for pain. 3. Resident #6 was originally admitted to the facility on 6/12/07 with multiple diagnoses including Multiple Sclerosis. The annual Minimum Data Set (MDS) assessment dated 2/21/18 indicated that Resident #6 did not have a pressure ulcer. The weekly wound assessment revealed that	F 657	discovery with the committee's appropriate members.	

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Resident #6 had developed a pressure ulcer on her sacrum on 3/23/18.

Resident #6's care plan was reviewed. The care plan dated 2/21/18 indicated that Resident #6 was at risk for skin breakdown/pressure ulcer and the goal was for her skin to remain intact with no redness or open areas. The care plan problem and goal were not revised to address the actual pressure ulcer.

On 5/23/18 at 11:40 AM, MDS Nurse #1 was interviewed. She verified that Resident #6 had a pressure ulcer on her sacrum and stated that she had failed to revise the care plan to address the actual open area/pressure ulcer.

On 5/24/18 at 9:26 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the care plan to be revised when a resident developed a pressure ulcer.

4. Resident #36 was admitted to the facility on 4/22/17 and most recently readmitted on 6/27/17 with multiple diagnoses that included dementia, hemiplegia (paralysis of one side of the body) affecting the right dominant side, and Diabetes Mellitus. The quarterly Minimum Data Set (MDS) assessment dated 4/2/18 indicated Resident #36' s cognition was moderately impaired.

A review of the medical record revealed a Nursing Assistant (NA) assigned to care for Resident #36 was not included in the care plan meetings or the care plan review/revision process for over a 1-year period.
- The care plan signature pages dated 5/2/17, 6/13/17, 7/6/17, 10/4/17, 1/2/18, 4/2/18, and

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5/2/18 all included no NA signatures.
- The care plan meeting notes for Resident #36 dated 8/16/17, 9/20/17, 10/18/17, 12/20/17, 2/21/18, 4/18/18, and 5/16/18 all indicated an NA was not present at the meetings.

An interview was conducted with MDS Nurse #1 on 5/23/18 at 11:50 AM. MDS Nurse #1 stated that care plan meetings were utilized to develop and review the care plans for all residents. She indicated that care plans were also reviewed in coordination with each MDS assessment by one of the MDS Nurses, dietary staff, activities staff, and the SW. She reported the staff that reviewed the care plan signed their name on the signature page to indicate the care plan had been reviewed. MDS Nurse #1 revealed that it was not normal facility practice for an NA assigned to the resident to attend the care plan meetings. She stated the NAs had busy schedules which would have made attending the meetings difficult. She additionally revealed it was not normal facility practice for an NA assigned to the resident to be included in the care plan review/revision process which included signing the signature page of the care plans.

This interview with MDS Nurse #1 continued. She stated she was the MDS Nurse assigned to Resident #36. She confirmed an NA was not present at any of the care plans meeting over the past year nor had an NA reviewed and signed the care plan for Resident #36.

An interview was conducted with MDS Nurse #2 on 5/23/18 at 2:00 PM. She stated that care plan meetings were utilized to develop and review the care plans for all residents. She indicated that care plans were also reviewed in coordination with each MDS assessment by one of the MDS

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F 657	Continued From page 37 Nurses, dietary staff, activities staff, and the SW. She reported the staff that reviewed the care plan signed their name on the signature page to indicate the care plan had been reviewed. She confirmed MDS Nurse #1 ' s statement that it was not normal facility practice for an NA to attend the care plan meetings. MDS Nurse #2 stated that NAs reviewed the baseline/initial admission care plan, but were not included in the review/revision process of subsequent care plans. An interview was conducted with the Administrator and Director of Nursing (DON) on 5/24/18 at 10:10 AM. Both reported they had not known if the regulations required a direct care NA to be included in the care planning process. They indicated their expectation was for the regulations to be followed. The DON added that the NAs assigned to the residents were usually the most familiar with them and therefore they should be aware of the care plan.	F 657		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by:	F 687		6/15/18

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F 687	Continued From page 38 Based on observation, responsible party, staff interviews and record review, the facility failed to provided foot care as ordered for 1 (Resident #41) of 1 residents reviewed for foot care. The findings included: Resident #41 was admitted on 11/21/14 with cumulative diagnoses of a left above the knee (AKA) amputation, Peripheral Artery Disease (PAD) and Adult Failure to Thrive. Review of a Podiatry Assessment and Doctor's Order Form dated 7/20/17 indicated Resident #41 required podiatry services due a history of a previous foot amputation, thick toenails and hyperkeratotic lesions (thickening of the outer layer of the skin). The form was signed by Resident #41 attending physician. Review of a podiatry note dated 10/24/17 read as follows: Left above the knee amputation. Toenails were long and in need of reduction. The right great toenail was ingrown. Hyperkeratotic lesion was likely covering an ulcer therefore, it was lightly debrided. Professional foot care was medical necessity and Resident #41 was to be seen in three months or sooner if necessary. Review of facility list of residents to be seen on 2/26/18 did not include Resident #41. The quarterly Minimum Data Set (MDS) dated 4/11/18 indicated severe cognitive impairment, no behaviors and total staff assistance for all her activities of daily living (ADLs).	F 687	F687 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 May 21st, 2018 survey and does not constitute an agreement or admission of Clapp's Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 06/15/2018. Key members of the QAPI committee met to determine the root cause of the citation related to F687 as well as a plan to correct the citation. The usual protocol for assembling the list of residents who need to be seen during the upcoming Podiatry visit is for the podiatry company to review the notes from the previous visit and create a list of residents who need to be seen again during the next visit, based on the podiatrist's notes. This list is sent to the Resident Coordinator at the facility who then adds any newly referred residents to be seen. Once it was discovered that Resident #41 had been	

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Resident #41's care plan last revised on 4/11/18 indicated required total staff assistance for her personal care. She was care planned for one pressure ulcer to her right foot.

Observation of Resident #41 on 5/21/18 at 2:35 PM, she was sitting in her wheelchair in the hall. The toenails to her right foot were noted long and jagged. They were discolored and appeared to be thick.

During a wound care observation on 5/22 at 11:42 AM, Nurse #2 stated the podiatrist provided foot care for Resident #41. She stated, "Doesn't appear he's seen her in a while". Nurse #2 stated the Staffing Coordinator was responsible for setting up podiatry visits.

Interview on 5/22/18 at 12:00 PM, Resident #41's Responsible Party (RP) stated Resident #41's foot care was provided by the facility podiatrist. She stated it had been a while since she was seen. She stated she was unaware of any upcoming podiatry visits.

Observation on 5/23/18 at 8:20 AM, Resident #41 was sitting up in bed with Nursing Assistant (NA) #3 feeding her breakfast. Resident #41's right foot toenails appeared as described on 5/21/18. NA #3 stated the aides were not allowed to trim her toenails. She stated she thought Resident #41 was being followed by the podiatrist.

Interview on 5/23/18 at 8:38 AM, the Staffing Coordinator stated she was responsible for scheduling the residents who needed to be seen every 3 months by the podiatrist. She stated Resident #41 was not on the list to be seen on 2/26/18. The Staffing Coordinator was unable to

left off the list to be seen during the February 2018 visit, the Podiatry company was called and the resident was seen on 5/30/2018. In order to ensure no other residents within the facility are in dire need of a podiatry visit, all residents feet were assessed by a nurse within the facility by 06/13/2018. No residents were found to be in need of a podiatry visit. Any resident in need of being seen will have a referral made and an appointment scheduled for the first available time. In order to ensure compliance with F687, the facility has initiated a new protocol in which the Staff Coordinator or Unit Manager will go through all podiatry notes after their visit and assemble the list of residents who need to be seen on the next visit. This list is to be compared to the list which the contract podiatry company sends as well. This new process change will prevent residents from being omitted in the future. The Staff Coordinator was educated on this new protocol by the Director of Nursing on 06/08/2018.

To ensure continued compliance with F687, the DON or Unit Managers will audit the podiatry notes and the list assembled by the Staff Coordinator for the next 3 scheduled quarterly podiatry visits. If the list is accurate and complete after 3 scheduled podiatry visits, the audit will then be reduced to once per year for one year. If substantial compliance continues to be found, the audit will then be discontinued. This audit will ensure the solutions put in place by the facility are

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F 687	Continued From page 40 offer an explanation as to why Resident #41 was not seen by the podiatrist on 2/26/18. Telephone interview on 5/24/18 at 9:18 AM, the Nurse Practitioner stated it was her expectation that all orders and treatments be done. She stated if Resident #41 was sick at the time the podiatrist visited the facility in February, it could account for the delay in foot care. Review of Resident #41's electronic and written medical record indicated she was treated for pneumonia 1/16/18 through 1/20/18 and treated prophylactically with Tamiflu (antiviral medication used to treat and prevent influenza from 1/22/18 through 1/31/18. Resident #41's health status at the time of the podiatrist visit on 2/26/18 was reviewed with the NP. She stated it would be her expectation that Resident #41's toenails would not have gone 7 months without attention. Interview on 5/24/18 at 9:25 AM, Nurse #1 stated when she documented the nail care as being completed in the electronic medical record, she was only ensuring her fingernails were trimmed. She stated she did not trim Resident #41's toenails due to her history of a left AKA and diagnoses of PAD. Nurse #1 stated Resident #41 required the services of the podiatrist for her foot care. Telephone interview on 5/24/18 at 9:44 AM, Nurse #3 stated she documented Resident #41's nail care in the electronic record and thought she looked at Resident #41's toenails last week. She stated she could not recall what they looked like but if she thought they needed to be trimmed, she would try to trim them unless it was contraindicated.	F 687	successful and sustained. In addition, the hall nurses will continue to observe resident's feet during their weekly skin checks on all residents and make podiatry referrals as needed. This citation and the plan of correction will be followed by the facility's QAPI Committee and results of this audit will be discussed in the bi-weekly/monthly meetings and as needed. The Director of Nursing is responsible for presenting this plan of correction to the QAPI Committee. Any areas of concern will be addressed and corrected upon discovery with the committee's appropriate members.	

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F 687	Continued From page 41 Interview on 5/24/18 at 10:17 AM, the Administrator and Director of Nursing stated it was their expectation that foot care be provided as order for Resident #41 and be done by a podiatrist as ordered due to her diagnosis of PAD and history of a left AKA.	F 687		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, Responsible Party (RP) and staff interviews and record review, the facility's staff failed to place a rolled wash cloth in a resident's right contracted hands per physician order to prevent worsening of the contracture for 1 (Resident #24) of 1 resident reviewed for range of motion and contractures. The findings included:	F 688	F688 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 May 21st, 2018 survey and does not constitute an agreement or admission	6/15/18

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F 688	Continued From page 42 Resident #24 was admitted to the facility on 2/23/94 with cumulative diagnoses of nontraumatic subdural hematoma and contractures. Resident #24's quarterly Minimum Data Set (MDS) dated 3/14/18 indicated the resident had moderate cognitive impairment, had no behaviors and needed total staff assistance for all her activities of daily living (ADLs). She was coded with range of motion impairment on one side of her upper body. Resident #24's last revised care plan dated 3/14/18 indicated she was to have right hand washed and dried daily, and a rolled wash cloth inside her right hand. Review of Resident #24's current electronic May 2018 orders read an order dated 9/25/17 to clean her right hand daily with soap and water, dry thoroughly, then place a rolled wash cloth in her right hand. Review of Resident #24's May 2018 Treatment Administration Record (TAR) revealed the nurses initialed daily at 7:15 AM indicating that Resident #24's right hand was washed with soap and water, dried thoroughly then a rolled wash cloth was placed in her right hand. The TAR indicated this treatment was ordered 9/25/17. Review of the undated electronic Daily Care Guide read as follows: I have a contracted right hand. Make sure the right hand was washed and dried daily with a rolled wash cloth in the right hand. Observation of Resident #24 on 5/21/18 at 2:19	F 688	of Clapp's Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 06/15/2018. Key members of the QAPI committee met to determine the root cause of the citation related to F688 as well as a plan to correct the citation. Upon investigation, it was discovered the orders for contracture management were not being entered in a way so that the CNA's could see the contraction prevention instructions for each resident. To achieve compliance with F688, the MDS Coordinators were in-serviced on 06/08/2018 by the Director of Nursing related to entering the contracture prevention instructions into the care plan so the CNA's can see the instructions and check off on having completed the tasks on the CNA's kiosks. All CNA's will also be in-serviced by the Director of Nursing by 06/15/2018 on how to view these contraction prevention instructions and the importance of contraction prevention measures being followed. On of before 06/15/2018, the MDS Coordinators and Director of Nursing audited all charts of residents	

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F 688	Continued From page 43 PM was conducted. She was sitting up in a wheelchair in her room. She had a severe right-hand contracture. There was no observed rolled up wash cloth in her right hand. Observation on 5/21/18 at 4:45 PM revealed no rolled wash cloth to Resident #24's right hand. Observation on 5/22/18 at 9:31 AM revealed no rolled wash cloth to Resident #24's right hand. Observation on 5/22/18 at 11:32 AM revealed no rolled wash cloth to Resident #24's right hand. Observation on 5/22/18 at 2:30 PM revealed no rolled wash cloth to Resident #24's right hand. Observation on 5/22/18 at 4:20 PM revealed no rolled wash cloth to Resident #24's right hand. Observation on 5/23/18 at 8:25 AM revealed no rolled wash cloth to Resident #24's right hand. Observation on 5/23/18 at 10:15 AM revealed no rolled wash cloth to Resident #24's right hand. Observation on 5/23/18 at 10:51 AM revealed no rolled wash cloth to Resident #24' right hand. At the time of the observation, an interview was conducted with Nursing Assistant (NA) #4. She stated she usually placed a rolled wash cloth in Resident #24's right hand but she forgot to do it today. NA #4 placed a wash cloth to Resident #24's right hand without difficulty and Resident #24 made no attempt to remove it. During an interview on 5/23/18 at 12:12 PM, Nurse #1 stated she signed off on the TAR that Resident #24's rolled wash cloth was in her right	F 688	with contracture prevention protocols in place to ensure the prevention protocol is entered in to the task care plan and viewable by the CNA on all shifts. All residents had their contracture prevention protocols in place as ordered and no areas of concern were found. To ensure this process is working appropriately, the Unit Managers or MDS Coordinator will observe 5 residents a week with contracture management protocols in place to ensure the protocols are being followed. The Director of Nursing will visit the residents at a time when the contracture management protocol is to be in place. The Director of Nursing will perform her observations on all shifts and on weekends. If substantial compliance is found during these observations, the audit will then be reduced to 5 residents per month, for 3 months. If substantial compliance is found, the audit will then be reduced to 5 residents per quarter, on-going. This on-going audit will ensure the facilities solutions are sustained. This citation and the plan of correction will be followed in the facility's QAPI Committee and results of this audit will be discussed in the bi-weekly/monthly meetings and as needed. The Director of Nursing is responsible for presenting this plan of correction to the QAPI committee. Any areas of concern will be addressed upon discovery with the committee's appropriate members.	

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F 688	Continued From page 44	F 688		

hand this morning. She stated maybe Resident #24 removed the wash cloth. Care plan was reviewed with Nurse #1. The care plan indicated Resident #24 refused restorative range of motion and contracture management. The care plan indicated Resident #24 was to have a rolled wash cloth in her right hand.

During an interview on 5/23/18 at 12:05 PM, NA #5 stated she only cleaned Resident #24's right hand daily. She stated Resident #24 did not have anything ordered for her right hand because it was closed too tight. NA #5 stated she followed what was indicated on the Daily Care Guide in the computer to know what interventions were care planned for Resident #24.

During an interview on 5/23/18 at 4:02 PM, NA #3 and NA #6 stated they used the Daily Care Guide in the computer to know what interventions were utilized for each resident they cared for. NA #3 stated she had never observed Resident #24 with a rolled wash cloth to her right hand. NA #6 stated she ensured Resident #24's right hand was clean but never placed a rolled wash cloth in her right hand.

During an interview on 5/23/18 at 2:00 PM, MDS Nurse #1 stated she was aware that Resident #24 and her RP refused splinting for her right hand but she was to have a rolled wash cloth to her right hand to prevent possible skin breakdown and worsening of her contracture. She stated Resident #24 was not known to remove the wash cloth from her right hand.

Observation on 5/23/18 at 2:17 PM revealed Resident #24 with a rolled wash cloth to her right hand.

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F 688	Continued From page 45 Observation on 5/23/18 at 4:00 PM revealed Resident #24 with a rolled wash cloth to her right hand. Observation on 5/24/18 at 8:20 AM revealed Resident #24 with a rolled wash cloth to her right hand. During a telephone interview on 5/21/18 at 4:14 PM, Resident #24's RP stated the resident had a right-hand contracture and that the staff were placing a rolled wash cloth in daily to prevent skin breakdown to her right hand. During an interview on 5/24/18 at 10:17 AM, the Administrator and Director of Nursing both stated it was their expectation that the staff ensure Resident #24 had a rolled wash cloth in her right hand daily as ordered by the physician.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to prevent a resident who required the extensive assistance of 1 staff for toileting from falling in the bathroom and sustaining a subarachnoid hemorrhage	F 689	F689 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.	6/15/18

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F 689	Continued From page 46 (bleeding in the space between the brain and the tissue covering the brain) and a subdural hematoma (pool of blood between the brain and its outermost covering). Resident #28 was assisted to the bathroom by Nursing Assistant (NA) #1, NA #1 exited the bathroom to retrieve items from the resident ' s room, and Resident #28 fell as she attempted to transfer independently from the toilet to her wheelchair while unattended by staff. This was for 1 of 5 residents reviewed for accidents. The findings included: Resident #28 was admitted to the facility on 11/21/17 and readmitted on 1/5/18 with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), adult failure to thrive, age related debility, weakness, and difficulty in walking. The admission Minimum Data Set (MDS) assessment dated 1/12/18 indicated Resident #28 ' s cognition was fully intact. She had no behaviors and no rejection of care. Resident #28 required the extensive assistance of 2 or more staff with bed mobility and the extensive assistance of 1 staff for toileting, dressing, and personal hygiene. She required the limited assistance of 1 staff for transfers. Resident #28 was not steady on her feet, but she was able to stabilize without staff assistance. She utilized a wheelchair and walker and had no impairment with her range of motion. Resident #28 was frequently incontinent of bladder and bowel. The Care Area Assessment (CAA) related to Activities of Daily Living (ADLs) for Resident #28 ' s 1/12/18 MDS indicated she required limited to	F 689	Preparation and submission of this plan of correction is in response to DHHS 2567 for the May 21, 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 06/15/2018. Key members of the QAPI committee met to determine the root cause of the citation related to F689. The committee determined the care plan for Resident #28 inaccurately addressed the resident's needs at the time of the fall. The committee also determined that tasks, such as fall interventions, which the CNAs are responsible for were not being layered in the care plan in such a way that the CNAs were able to see the tasks on their kiosks. To minimize risk of Resident #28 having further accidents, the care plan was updated correctly so that the CNA's tasks and responsibilities, including fall interventions, would show up in the task care plan for the CNA's to see. Being able to view this information allows the CNA's to know specifically the assistance	

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F 689	Continued From page 47 extensive assistance of 1 staff with ADLs related to a debilitated state, weakness, and balance problems. The CAA related to falls for Resident #28 ' s 1/12/18 MDS indicated she was at risk for falls with injury. Resident #28 ' s plan of care included the focus area of the potential for falls. This area was initiated on 11/28/17 and reviewed on 1/12/18. The interventions included, in part, "Staff to monitor me during toileting task if assisted to bathroom ...transfer back to chair/bed. Do not leave me alone in bathroom." A review was conducted of the NA documentation for Resident #28 ' s toileting task from 2/1/18 through 3/1/18. The NA documentation indicated Resident #28 ' s level of required assistance for toileting varied from the limited assistance of 1 staff to total dependence of 2 or more staff. An incident report dated 3/1/18 and written by Nurse #1 indicated Resident #28 had an unwitnessed fall with injury on 3/1/18 at 8:15 AM. Resident #28 ' s injuries were noted as, "skin tear - superficial, bruise/redness, hematoma". Nurse #1 was called to Resident #28 ' s bathroom by staff. Resident #28 had fallen from the toilet onto the floor as she was attempting to transfer into her wheelchair. Resident #28 was noted to have two skin tears, one to the left elbow and one to the left knee. Both skin tears were cleaned and dressed. An ice pack was applied to Resident #28 ' s head. She was assisted back to her wheelchair by 2 staff. The physician and Responsible Party (RP) were contacted. The Fall Scene Investigation (FSI) Report related to Resident #28 ' s fall on 3/1/18 at 8:15 AM	F 689	resident needs during toileting tasks. Specific interventions which have been implemented since resident's first fall on 03/01/2018 and to minimize risk of falls include: Resident given non-skid socks and educated on the importance of wearing them and education provided on not attempted to transfer from any surface without assistance. The Task Care plan was updated on 05/23/2018 to reflect all appropriate fall interventions for Resident #28. All current charts of residents with fall interventions in place were audited by the MDS Consultants prior to 06/15/2018 to ensure the interventions which CNAs were responsible for were both accurate and viewable by the CNA. Also prior to 06/15/2018, the Director of Nursing and MDS Coordinator completed a full audit of all physical fall interventions and verified the physical interventions were in place. The facility has now initiated a new process for entering CNA tasks into the care plan in order for the CNA to be able to see their required tasks/duties. All nurses and CNAs will be re-educated on where to view the task care plan by 06/15/2018 by DON or Unit Manager. They were also educated that interventions in which CNAs are responsible for will be viewable on the task care plan so the CNA can view the care planned interventions every shift. The facility has created a QAPI audit for monitoring the fall interventions listed on the resident's care plan, task care plan, and are being followed as written. Due to the citation and in order to ensure	

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F 689	Continued From page 48 indicated NA #1 was the first staff present following Resident #28 ' s unwitnessed fall. Resident #28 was found on the floor in her bathroom after attempting to self-transfer. Resident #28 was assessed as alert and oriented prior to the fall. She stated she was trying to transfer to her wheelchair. The FSI Report provided a written statement from NA #1. NA #1 indicated Resident #28 pressed her call light on 3/1/18 around 7:50 AM. NA #1 answered the call light and proceeded to assist Resident #28 with her bathing and dressing. She then assisted Resident #28 to her bathroom (located inside of Resident #28 ' s bedroom). NA #1 reported that after she had transferred Resident #28 from her wheelchair to the toilet she had stepped out of the bathroom to pick-up the resident ' s nightgown and linens from the floor in her room. NA #1 indicated while she was outside of the bathroom she heard Resident #28 scream. She noted that Resident #28 had not called out verbally for her assistance and she had not rang the call bell. NA #1 indicated she reminded Resident #28 to use the call light for assistance in the bathroom. A nursing note dated 3/1/18 and written by Nurse #1 confirmed the information in the incident report dated 3/1/18. The note additionally indicated Resident #28 had bumped her head on the floor and neurological assessments were initiated. A physician ' s order dated 3/1/18 indicated neurological assessments for Resident #28. A review was conducted of the neurological assessments dated 3/1/18 beginning at 8:30 AM. These assessments indicated no concerns with Resident #28 ' s condition through the assessment completed on 3/1/18 at 11:30 AM.	F 689	compliance on-going, 5 Care Plans will be audited per week x 4 weeks by the Director of Nursing to ensure proper fall interventions are listed on the resident's care plan, task care plan, and any physical interventions are in place. If substantial compliance is found, the audit will be reduced to 2 Care Plans per month x 3 months. Once the audits are complete the QAPI committee will review the audits and determine the frequency of the audits going forward. Also to ensure on-going compliance, the unit managers or director of nursing will observe 5 CNA's per week for 4 weeks during one toileting task to ensure care planned interventions are being followed by CNA. If substantial compliance is found during the weekly audit, the audit will then be reduced to 5 CNAs monthly for 3 months. These audits will be completed on all shifts as well as on weekends. If substantial compliance continues to be found during the monthly audit, spot checks will continue by unit managers on an on-going basis. The QAPI committee will discuss the progress and results of this Plan of Correction in the bi-weekly/monthly meetings and more often if needed. The Director of Nursing will be responsible for presenting this plan of correction to the QAPI committee. Any areas of concern will be addressed accordingly by the appropriate committee members.	

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A nursing note dated 3/1/18 at 12:02 PM indicated Nurse #1 was called to Resident #28 ' s room. Resident #28 had vomited and was shaking. She stated her head hurt and she didn ' t feel good. The physician was notified and an order was received to send Resident #28 to the Emergency Room (ER) for evaluation.

The ER records indicated Resident #28 was seen in the Emergency Department on 3/1/18 and a neurology consultation was ordered. The neurology consultation indicated Resident #28 presented with a traumatic Subarachnoid Hemorrhage (SAH) on the right side. A head CT (computerized tomography) scan showed suspected Subdural Hematoma (SDH). She was admitted to the hospital for repeat CT head scans and monitoring. This consultation noted that it was discussed whether Resident #28 was more appropriate on neurology service or medicine service, but medicine service had not felt comfortable managing the size of Resident #28 ' s bleed. The hospital records indicated Resident #28 remained in the hospital from 3/1/18 through 3/5/18 when she was discharged back to the facility.

Resident #28 ' s plan of care related to falls was updated on 3/5/18 with the handwritten intervention, "Do not leave Resident alone in bathroom." This was a duplicate intervention as it was previously in place on the care plan.

A physician ' s progress note dated 3/28/18 indicated Resident #28 was readmitted to the facility following a hospital stay for a fall resulting in closed head trauma, SAH, and SDH. Repeated head CTs at the hospital showed

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F 689	Continued From page 50	F 689		

stability.

A review of the medical record indicated Resident #28 has returned to her baseline health status.

The NA Daily Care Guide, undated, for Resident #28 was reviewed on 5/22/18. The interventions for Resident #28 included, in part, "Staff to monitor me during toileting task if assisted to bathroom ...transfer back to chair/bed. Do not leave me alone in bathroom."

An interview was conducted with the DON on 5/22/18 at 3:05 PM. The DON stated that the interventions on the care plan were linked to the NA Daily Care Guide interventions. She stated if the intervention was in place on the care plan, then it was also in place on the NA Daily Care Guide. The intervention for Resident #28 that indicated, "Staff to monitor me during toileting task if assisted to bathroom ...transfer back to chair/bed. Do not leave me alone in bathroom" was reviewed with the DON. She confirmed this intervention was in place on the care plan and on the NA Daily Care Guide at the time of Resident #28 ' s 3/1/18 fall.

An interview was conducted with NA #1 on 5/22/18 at 2:25 PM. She stated she had worked at the facility for about 3 years and she was familiar with Resident #28. She reported Resident #28 was a fall risk and she had several falls. She confirmed she was working with Resident #28 on 3/1/18 at the time of her 8:15 AM fall. She stated she had taken Resident #28 to the bathroom after she assisted her with bathing. NA #1 indicated she transferred Resident #28 to the toilet, she stayed in the bathroom during the task of toileting, and she

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F 689	Continued From page 51	F 689		

changed Resident #28 ' s brief. She reported prior to transferring Resident #28 off of the toilet and back to her wheelchair, she left the bathroom to retrieve a roll of trash bags she had left in Resident #28 ' s room. She indicated she was out of the bathroom for about 5 seconds when she heard Resident #28 scream, she re-entered the bathroom, and she found her on the floor. NA #1 confirmed that Resident #28 had fallen while attempting to self-transfer without staff present.

This interview with NA #1 continued. She was asked how she was made aware of fall risk interventions that were in place. She stated the NA kiosk, an electronic record of the NA Daily Care Guide, had a list of all of the interventions for each resident. The NA kiosk for Resident #28 was reviewed with NA #1. The kiosk included the intervention, "Staff to monitor me during toileting task if assisted to bathroom ...transfer back to chair/bed. Do not leave me alone in bathroom." NA #1 acknowledged she had assisted Resident #28 to the bathroom and left her alone while she retrieved items from the resident ' s room. She revealed she had not known this intervention was in place for Resident #28. She reported that she thought Resident #28 was able to toilet independently and that she only needed assistance changing her brief.

An interview was conducted with Nurse #1 on 5/23/18 at 9:06 AM. She stated she had worked at the facility for over 11 years and she was familiar with Resident #28. She reported Resident #28 was a fall risk and she had several falls. She confirmed she was working with Resident #28 on 3/1/18 at the time of her 8:15 AM fall. She indicated Resident #28 had lost her balance and fell off of the toilet onto her bathroom

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F 689	Continued From page 52 floor. She stated Resident #28 had a couple of skin tears and redness noted to her head. Nurse #1 reported she assessed Resident #28 ' s neurological status and noted no concerns with her condition. She obtained an order for neurological assessments from the physician and had completed the assessments with no noted changes in condition until Resident #28 presented with vomiting and shaking early that same afternoon (3/1/18). She indicated Resident #28 was then sent to the ER for evaluation and was admitted to the hospital. An interview was conducted with Resident #28 on 5/23/18 at 9:30 AM. She indicated she had fallen multiple times at the facility. She stated she needed help getting on and off the toilet and changing her briefs after toileting. The 3/1/18 fall at 8:15 AM was discussed with Resident #28. She stated she was in the bathroom, the NA (NA #1) left the bathroom, and she tried to get up on her own. She reported she lost her balance and fell and hit her head on the bathroom floor. A follow up interview was conducted with the DON on 5/24/18 at 10:10 AM. She stated the purpose of care plan interventions related to falls were to reduce the risk for falls and to avoid preventable falls. She indicated she expected staff to be aware of care plan interventions and to implement them at all times.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		6/15/18

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	345015	A. BUILDING _____ B. WING _____	05/24/2018

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F 758	Continued From page 53	F 758		

but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic

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F 758	Continued From page 54 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assess a resident who was on antipsychotic medication for extrapyramidal symptoms (EPS), a drug induced movement disorder, for 1 of 3 sampled residents on antipsychotic medication (Resident # 29). Findings included: Resident #29 was originally admitted to the facility on 3/22/18 with multiple diagnoses including dementia and unspecified psychosis. The admission Minimum Data Set (MDS) assessment dated 3/28/18 indicated that Resident #29 had moderate cognitive impairment and had received an antipsychotic medication during the 7 day assessment period. On 3/22/18, Resident #29 had a doctor's order for Seroquel (an antipsychotic medication) 50 milligrams (mgs) 1 tablet at 4 PM and at 10 PM for unspecified psychosis. Review of Resident #29's medical records revealed that there was no assessment for EPS completed as of 5/23/18. On 5/23/18 at 11:55 AM, the Director of Nursing (DON) was interviewed. The DON stated that residents on antipsychotic medication should have AIMS (Abnormal Involuntary Movement Scale) test, a test used to assess for EPS, completed on admission and then every 6 months per facility's policy. She added that she could not	F 758	F758 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 May 21st, 2018 survey and does not constitute an agreement or admission of Clapp's Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 06/15/2018. Key members of the QAPI committee met to determine the root cause of the citation related to F758 as well as a plan to correct the citation. The Committee determined after investigation that the facility was failing to perform the initial Abnormal Involuntary Movement Scale assessment in order to get a baseline of the resident's condition and assess for	

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F 758	Continued From page 55 find an AIMS test for Resident #29, it was missed.	F 758	immediate side effects of antipsychotic medications. To achieve compliance with F758, an AIMS assessment was completed for Resident #29 by the Director of Nursing prior to the end of the annual survey. All other residents on anti-psychotics were assessed by the Director of Nursing on 06/08/2018 to ensure no AIMS assessment had been missed, according to the regulations. No other areas of concern were found. All other AIMS assessments have been completed according to regulation. The Director of Nursing was also educated by the Administrator on 06/08/2018 related to the regulations on the completion of AIMS assessments. To ensure substantial compliance with F758 continues, the MDS Coordinator or Unit Managers will review the New Physicians Orders Report weekly at minimum for 6 months to verify any residents started on antipsychotics or new residents admitted with antipsychotics have had an AIMS assessment completed timely in order to assess for immediate side effects of the medication. If substantial compliance is made with the weekly audits, the audit will be reduced to monthly for 6 months. If substantial compliance continues to be found, the audit will be discontinued. The Pharmacy Consultant will also review all residents on anti-psychotics monthly to ensure AIMS was completed according to regulation. This citation and the plan of correction will be followed by the facility's QAPI Committee and results of this audit will be discussed in the bi-weekly/monthly	

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F 758	Continued From page 56	F 758	meetings and as needed. The Director of Nursing is responsible for presenting this Plan of Correction to the QAPI committee. Any areas of concern will be addressed immediately with the committee's appropriate members.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observation, manufacturer ' s specifications and staff interview, the facility failed to ensure that the medication error rate was 5% or less as evidenced by two (2) errors of twenty-five (25) opportunities resulting in an 8% error rate (Resident #24 and #48). The findings included: 1. Resident #24 was admitted to the facility 2/23/1994. Cumulative diagnoses included gastrostomy tube (a tube inserted in the abdominal wall for administration of nutrition). Resident #24 had a physician ' s order to administer metoprolol tartrate (hypertension medication) 25 milligrams via tube and Lasix (diuretic) 20 milligrams via tube at 2:00 PM. On 5/22/18 at 2:05 PM, Resident #24 was observed during medication pass. Nurse #2 was observed to prepare the metoprolol tartrate and Lasix, crush both medications together and	F 759	F759 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 May 21st, 2018 survey and does not constitute an agreement or admission of Clapp's Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance	6/15/18

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F 759	Continued From page 57 administered the medications via gastrostomy tube. On 5/22/18 at 2:18 PM, an interview was conducted with Nurse #2 who stated she thought it was all right to crush them together and not administer them one at a time since it was only two (2) medications. She was not aware that they should have been administered separately with a water flush between medications. On 5/23/18 at 12:04 PM, an interview was conducted with the Director of Nursing who stated her expectation was for nursing staff to follow the policy for medication administration via gastrostomy tube which stated if administering more than one medication, flush with 5 cubic centimeters of water between medications. 2. Resident #48 was admitted to the facility on 4/11/18 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). A drug information leaflet for Symbicort provided by the facility was reviewed. The drug information indicated "if your prescribed dose is 2 puffs, wait at least one minute between them. If you are using other inhalers at the same time, wait at least 1 minute between the use of each medication and use this drug last". Resident #48 had a doctor's order dated 4/11/18 for Symbicort (used to reduce exacerbation in patients with COPD) 160-4.5 microgram (mcg) inhaler - 2 puffs twice a day for COPD. On 5/23/18 at 9:00 AM, Nurse # 4 was observed during the medication pass. She was observed to prepare and to administer the resident's medications including Symbicort. Nurse #4 was	F 759	with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 06/15/2018. Key members of the QAPI committee met to determine the root cause of the citation related to F759 as well as a plan to correct the citation. The committee determined the two nurses who made medication errors while being observed by the surveyor needed education related to either inhaler administration or medication administration via gastrostomy tube. To achieve substantial compliance with F759, all Full-time, Part-Time, PRN and Contracted RNs and LPNs were educated on proper inhalation and gastrostomy tube medication administration by the Director of Nursing prior to 06/13/2018. The education specifically addressed medication administration via gastrostomy tube as well as the time limitations to be followed when administering inhalers. To ensure on-going compliance with F759, education related to medication administration related to inhalation and gastrostomy tubes will be provided to all nursing staff yearly. The Director of Nursing or Unit Manager will observe 3 different nurses per week for 4 weeks during their medication pass to ensure no errors are made related to gastrostomy tube medication administration and inhalation therapy. The Medication Administration audit will be done on all shifts, on various halls and will include weekends. The Director of Nursing will ensure no medication errors are made during each pass. If substantial	

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F 759	Continued From page 58 observed to administer 2 puffs of Symbicort without waiting at least a minute between puffs. On 5/23/18 at 9:50 AM, Nurse #4 was interviewed. She stated that she should have waited 1 minute between puffs per the manufacturer's recommendation. On 5/24/18 at 9:26 AM, interview with the Director of Nursing (DON) was conducted. She stated that she expected the Nurse to wait at least 1 minute between puffs when administering more than 1 puff per the manufacturer's recommendation.	F 759	compliance is found during the weekly audit, the audit will then be reduced to 3 per month for 3 months. If substantial compliance is found after the monthly audits, the audit will be reduced to 5 nurses per quarter, on-going. This citation and the plan of correction will be followed in the facility's QAPI Committee and results of this audit will be discussed in the bi-weekly/monthly meetings and as needed. The Director of Nursing will be responsible for presenting this Plan of Correction to the QAPI Committee. Any areas of concern will be addressed immediately with the committee's appropriate members.	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		6/15/18

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F 842	Continued From page 59 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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F 842	Continued From page 60 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, the facility failed to maintain complete and accurate medical records for restorative nursing for two (2) of three (3) residents (Resident #4 and Resident #8). The findings included: 1. Resident #4 was readmitted to the facility 2/16/18. Cumulative diagnoses included unsteadiness on his feet, diabetes, dementia and chronic obstructive pulmonary disease(COPD). An admission Minimum Data Set (MDS) dated 2/23/18 indicated Resident #4 was cognitively intact. He required extensive assistance with all activities of daily living (ADL) except eating. Balance was impaired and he was only able to stabilize with staff assistance. Range of motion was coded as impairment of both lower extremities. A care plan dated 3/8/18 revealed Resident #4 received restorative nursing for transfers and walking. On 5/21/18 at 3:49 PM, an interview was conducted with Resident #4 who stated he was unable to walk. He stated his legs just weren't strong enough for him to walk. A review of the restorative nursing program	F 842	F842 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 May 21st, 2018 survey and does not constitute an agreement or admission of Clapp's Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 06/15/2018. Key members of the QAPI committee met to determine the root cause of the citation related to F842 as well as a plan to correct the citation. The committee determined the MDS Coordinator had been insufficiently educated related to the documentation required with a restorative	

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F 842	Continued From page 61 records revealed Resident #4 was referred to the restorative nursing program for transfers and walking on 3/8/18. Goals for Resident #4 stated he would transfer sit to stand x 10 repetitions with standby to contact guard assist two times daily x seven days a week and ambulate with rolling walker 50 feet x 2 in hallway two times daily x seven days a week. There was no documentation in the monthly nursing summary check off list or restorative nursing progress notes to evaluate the progress towards restorative nursing care plan goals. On 5/23/18 at 11:20 AM, an interview was conducted with MDS Nurse #1 who stated she had overseen the restorative nursing program since January 2018. The nursing assistants were responsible for carrying out the restorative program for their assigned residents. When a resident was placed on the restorative nursing program, she completed the forms for restorative nursing which included the restorative nursing program needs identification sheet, the resident care plan for restorative nursing and entered what type of restorative program had been initiated in the nursing assistant kiosk. The nursing assistants documented in the kiosk what had been completed for restorative nursing on their shift. MDS Nurse #1 said she completed the restorative nursing summary check off list monthly and wrote summary notes quarterly in conjunction with their MDS assessments. She stated Resident #4 should have had restorative documentation completed for March 2018 and April 2018. On 5/23/18 at 11:57 AM, an interview was conducted with the Director of Nursing. She said, once the restorative care plan was in place, the	F 842	nursing program. To achieve substantial compliance with F842, the Director of Nursing provided education on 06/08/2018 to the MDS Coordinator per the RAI manual related to the documentation requirements of a restorative nursing program. Prior to 06/15/2018, the Director of Nursing or Nurse Manager will also audit the facility's current restorative program and identify any documentation that is behind. The MDS coordinator, after being properly educated will update the documentation to reach compliance. To ensure continued compliance with F842, the Director of Nursing will audit 5 restorative residents per month for 3 months to ensure all documentation is up to date with all residents. This audit will monitor that the facility's solution of thoroughly educating the MDS Coordinator was sufficient and compliance will be sustained. If substantial compliance is found with the monthly audit, the audit will then be reduced to quarterly for three quarters. Should substantial compliance continue to be found, the QAPI committee will then decide, based on the audit results, how often the audit should be done, on-going. This citation and the plan of correction will be followed in the facility's QAPI Committee and results of this audit will be discussed in the bi-weekly/monthly meetings and as needed. The Director of Nursing is responsible for presenting the plan of correction to the QAPI Committee. Any areas of concern will be addressed	

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restorative program should be done two times daily seven days per week. She stated she expected MDS Nurse #1 to complete a thirty (30) day assessment and a quarterly summary note. She said the restorative nursing summary check list should be completed monthly.

On 5/23/18 at 2:10 PM, an interview was conducted with nursing assistant (NA) #2. She stated she provided care for Resident #4 during the day shift (7:00AM-3:00 PM) and performed exercises with sit to stand.

2. Resident #8 was admitted to the facility 2/7/18. Cumulative diagnoses included cerebrovascular accident (CVA) with flaccid hemiplegia (paralysis) affecting the right dominant side and muscle weakness.

A quarterly Minimum Data Set (MDS) dated 5/14/18 indicated Resident #8 had short and long-term memory impairment and was moderately impaired in decision-making. She required extensive assistance with transfers. No ambulation occurred during the assessment period. Balance was impaired and she was only able to stabilize with staff assistance. Range of motion was coded as impairment on one side for upper and lower extremity.

A care plan dated 5/14/18 revealed Resident #8 received restorative nursing for transfers and walking.

A review of the restorative nursing program records revealed Resident #8 was referred to the restorative nursing program for transfers and walking on 2/28/18. Goals included transfers with contact guard assist using gait belt, verbal visual

discovery with the committee's appropriate members.

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F 842	Continued From page 63	F 842		

and tactile cues for instruction and ambulation to the bathroom and to and from the nursing station using contact guard assistance and gait belt. There was no documentation in the monthly nursing summary check off list or restorative nursing progress notes to evaluate the progress towards restorative nursing care plan goals.

On 5/23/18 at 11:20 AM, an interview was conducted with MDS Nurse #1 who stated she had overseen the restorative nursing program since January 2018. The nursing assistants were responsible for carrying out the restorative program for their assigned residents. When a resident was placed on the restorative nursing program, she completed the forms for restorative nursing which included the restorative nursing program needs identification sheet, the resident care plan for restorative nursing and entered what type of restorative program had been initiated in the nursing assistant kiosk. The nursing assistants documented in the kiosk what had been completed for restorative nursing on their shift. MDS Nurse #1 said she completed the restorative nursing summary check off list monthly and wrote summary notes quarterly in conjunction with their MDS assessments. She stated Resident #8 should have had restorative documentation completed for March 2018 and April 2018.

On 5/23/18 at 11:57 AM, an interview was conducted with the Director of Nursing. She said, once the restorative care plan was in place, the restorative program should be done two times daily seven days per week. She stated she expected MDS Nurse #1 to complete a thirty (30) day assessment and a quarterly summary note. She said the restorative nursing summary check

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	345015	A. BUILDING _____ B. WING _____	05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPP'S CONVALESCENT NURSING HOME INC	500 MOUNTAIN TOP DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 64 list should be completed monthly. On 5/23/18 at 2:10 PM, an interview was conducted with nursing assistant (NA) #2. She stated she provided care for Resident #8 during the day shift (7:00AM-3:00 PM). NA #2 stated she assisted Resident #8 with transfers and ambulation daily and used a gait belt for ambulation. She said Resident #8 was doing well with ambulation.	F 842		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. 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 resident and staff interviews and record review, the facility's Quality Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification	F 865	F865 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.	6/15/18

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F 865	Continued From page 65 survey of 4/19/17. This was for three deficiencies recited during a recertification survey of 5/24/18 in areas of Quality of Life at F689, Pharmacy Services at F758 and Administration at F842. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain and effective Quality Assessment and Assurance program. The findings included: This citation is cross referenced to: F689- Based on record review, resident interview, and staff interview, the facility failed to prevent a resident who required the extensive assistance of 1 staff for toileting from falling in the bathroom and sustaining a subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain) and a subdural hematoma (pool of blood between the brain and its outermost covering). Resident #28 was assisted to the bathroom by Nursing Assistant (NA) #1, NA #1 exited the bathroom to retrieve items from the resident's room, and Resident #28 fell as she attempted to transfer independently from the toilet to her wheelchair while unattended by staff. This was for 1 of 5 residents reviewed for accidents. F758- Based on record review and staff interview, the facility failed to assess a resident who was on antipsychotic medication for extrapyramidal symptoms (EPS), a drug induced movement disorder, for 1 of 3 sampled residents on antipsychotic medication (Resident # 29). F842- Based on record review, resident and staff	F 865	Preparation and submission of this plan of correction is in response to DHHS 2567 for the May 21st, 2018 survey and does not constitute an agreement or admission of Clapp's Nursing Home of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 06/15/2018. Key members of the QAPI committee met to determine the root cause of the citation related to F865 as well as a plan to correct the citation. The committee determined they had failed to continue auditing the areas which were cited on the previous year's annual survey in their QAPI meetings. Failure to continue to audit these areas caused the facility to be unable to recognize when systems were not working successfully. To achieve compliance with F865, the facility will meet every other week for two months to more closely monitor the audits and education required for every deficiency cited. After two months of meeting every other week, the QAPI meetings will resume to monthly. Areas of concern related to any of the audits or new systems initiated will be discussed	

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F 865	Continued From page 66 interview, the facility failed to maintain complete and accurate medical records for restorative nursing for two (2) of three (3) residents (Resident #4 and Resident #8). Interview on 5/24/17 at 10:17 AM, the Administrator stated she was unable to determine how their systems failed until she reviewed the plan of correction for recertification survey of 4/19/17.	F 865	immediately by the appropriate committee members. Action plans will be initiated to correct any areas of concern immediately as well. The facility has a new Administrator of record which became effective in May 2018. The new Administrator will educate all QAPI members on the requirements of an effective QAPI Program to include monitoring the continued success of corrected survey-related deficiencies. The three F-tags which were cited on both the 2017 survey as well as the current survey were brought to the QAPI committee on 06/15/2018. All new processes put in place to correct the three deficiencies were assessed by the QAPI committee and no areas of concern were found. The Committee determined the QAPI program related to F865 was brought back in to compliance on 06/15/2018. To ensure on-going compliance with F865, the new Administrator will review all QAPI Program documents related to F-689, F-842 and F-758 prior to the bi-weekly/monthly QAPI Meetings for one year in order to ensure the QAPI program is properly monitoring all new processes and audits as a result of the state cited deficiencies. The QAPI Meetings are prepared and presented by the Director of Nursing. Although the Administrator is an active member of the QAPI Committee, the Administrator will now be responsible for ensuring all areas are being monitored prior to the Committee meeting. If substantial compliance is found, the audit will be discontinued. Any areas of concern will be addressed upon discovery by the	

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F 865	Continued From page 67	F 865	Administrator.	