STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345024	A. BUILDING _____ B. WING _____	12/07/2017

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CLAPPS NURSING CENTER INC	5229 APPOMATTOX ROAD PLEASANT GARDEN, NC 27313

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §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 observations, resident interview, staff interview and record review, the facility failed to honor food preferences for 1 of 3 residents (Resident #33) reviewed for choices. Finding included:	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	1/4/18

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

Electronically Signed | 12/28/2017

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F 561	Continued From page 1 Resident #33 was admitted to the facility on 11/13/17 with a diagnosis of end stage renal disease, dependence of renal dialysis, kidney transplant status, Type 2 Diabetes Mellitus (DM), abnormal weight loss, weakness and severe protein calorie malnutrition. Review of the most recent Minimum Data Sheet (MDS) dated 11/27/17 revealed that Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15. The resident was cognitively intact and able to make decisions on daily life. The resident required extensive assistance with transfer, dressing, toilet use and bathing. The resident was also coded to have limited assistance with eating and personal hygiene. A review of Resident #33 admission dietary preferences dated 11/10/17 indicated liked: cranberry juice, unsweet tea, and meat with sauce. Disliked: coffee, water, milk, chicken, pork chops and fruit plates. Observation of Resident #33 meal ticket on 12/5/17 at 9:19am listed liked: milk. The meal ticket also listed disliked: dried beans, banana, potatoes and orange juice which is different from the admission preference list. At that point, I interviewed the resident and he indicated the meal ticket was incorrect and stated "I tell them that every time they bring me my tray. I tell them I love dried bean, potatoes and orange juice. I also tell them I hate milk but they still bring it." The resident also stated he asked for oatmeal every morning. An observation on 12/5/17 at 9:34am, Nursing Assistant (NA) #4 brought in cereal to Resident #33 and stated "there was no more oatmeal."	F 561	for the December 7, 2017 survey and does not constitute an agreement or admission of Clapp□s Nursing Center of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it□s allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of January 4, 2018. A QAPI meeting was held on December 26, 2017 to discuss this deficiency. A root cause analysis was completed and it was determined, due to the facility trying to give residents as many choices as possible, a select few residents were being offered dietary choices that did not follow their diet ordered by the physician. Currently the food preferences and dietary restrictions are discussed with the resident within the first 5 days of a resident admitting to the facility by the Dietary manager or Registered Dietitian. The information gathered is then entered into an electronic dietary program. We use this program to maintain our resident food preferences and dietary restrictions. The information is then printed out on resident meal tickets. In our investigation	

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F 561	Continued From page 2 An interview with NA #4 on 12/05/17 at 3:44pm revealed resident received a fruit plate for lunch. She stated the resident wanted the main dish which had potatoes and broccoli listed. NA #4 went back to the kitchen but it was not available. She further stated that because they are one of the last halls to get trays, on most occasions if a resident wanted something different, the items were discarded and dishwashing had already started. NA #4 indicated she offered the resident soup and crackers instead. An interview with Resident #33 on 12/6/17 at 10:08am, Resident #33 stated "breakfast was good except I didn't get oatmeal, I got grits." He stated he preferred oatmeal. The meal ticket did not have updated dislikes. He indicated someone from dietary came in the morning of 12/5/17 and asked him what his likes and dislikes were and they would be updating his preferences. An interview with Resident #33 on 12/7/17 at 9:20am, stated "breakfast was good but still did not get oatmeal." He further stated "I tell those girls who bring the trays every morning." An interview with NA #2 on 12/7/17 at 9:42am revealed she usually worked the 200 hall. She stated Resident #33 did request oatmeal to be on his breakfast tray several times. She indicated that when he requests oatmeal on his breakfast tray she informs her nurse for that hall. An interview with Nurse #2 on 12/7/17 at 9:57am revealed she was aware of the "grits versus oatmeal issue." Nurse #2 stated she was informed by NA #2 that Resident #33 preferred oatmeal over grits and had informed someone	F 561	it was found dietary preferences were not taken by dietary upon readmission. This was the root cause of the resident not receiving his preferred foods at meals. Our Performance Improvement Plan will change how we are obtaining food preferences and discussing the resident□s diet and only offering a menu that adheres to the resident□s dietary restrictions. On admission the admission coordinator will review with the resident and/or resident responsible party, the resident□s food preferences. This will be recorded and taken to the dietary department immediately. The Dietary Manager, Registered Dietitian, and lead cooks on morning and evening shift were retrained on December 26th and December 27th to place the information in to the electronic dietary program. The preferences will then be on resident□s meal ticket which is printed every meal and placed on the resident□s tray. If the resident□s food preference does not follow the recommended diet by the physician, the Admissions Coordinator will refer either the Speech Therapist, Dietary Manager, Dietitian, or Weekend Supervisor to the resident depending on what the resident and/ or responsible party does not agree with. The previous listed staff will educate the resident and/or responsible party on the risk of not following the recommended diet. If the resident and/or responsible party still wants to receive a diet or preference that is not recommended for the resident, the resident□s physician will be contacted by a nurse to inform the physician of the	

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F 561	Continued From page 3 from dietary in the past. Nurse #2 could not remember the date or the person she spoke to. She stated that they told her they would make the changes to his preferences. An interview on 12/6/17 at 10:08am Resident #33 someone came in that morning and asked what he would like for lunch and dinner. He was given options for lunch and dinner and stated he requested lasagna for lunch and pepperoni pizza for dinner. An observation on 12/6/17 at 12:37pm, the resident's meal ticket indicated an ordered lunch as lasagna, salad without tomatoes, green beans, peach cobbler and garlic bread. Resident #33's tray had a pimento cheese sandwich, salad without tomatoes, green beans, peach cobbler and iced tea. The resident stated he told the person who brought the tray he didn't get what he had requested. An interview with the cook on 12/6/17 at 12:52 revealed the resident's daily menu request indicated he chose lasagna for lunch. She stated she asked the dietary manager if Resident #33 could have lasagna for lunch and was told to replace it with a pimento sandwich due to his physician diet order. She did not inform the resident of the change. An interview with Dietary manager (DM) on 12/6/17 at 12:42pm revealed she instructed the cook to change Residents #33's lunch tray to a pimento cheese sandwich from lasagna because of his potassium restrictions. The dietary manager stated she did not inform the resident of the change to the meal he requested. She did report Resident #33 like's foods high in potassium and she has sat down with him on 12/5/17 and instructed him on the importance of adhering to a	F 561	resident□s preference. The Nurse will then verbally take any new Physician Orders. These preferences will also be discussed at every care plan meeting to ensure the resident and/or responsible party does no want to make any changes to their food preferences. In addition to obtaining resident□s preferences upon admission, residents on a specialty diet will only be offered a menu that reflects their dietary restrictions. The Administrator or Dietary Manager will be responsible for implementing the Performance Improvement Plan. Monitoring will include auditing at least 5 new admissions weekly for 4 weeks to ensure the admission coordinator has filled out the appropriate paper work after discussing food preferences with the resident. The audit will include interviewing 5 residents per week to ensure they are not being offered a meal that does not adhere to their ordered diet. In addition, the audit will also include verifying the dietary department has updated the electronic dietary system. After 4 weeks of auditing, the Quality Assurance Nurse will then audit 10 resident□s dietary preferences monthly for 2 months to ensure the residents are receiving their food preferences while not being offered foods not in accordance with their ordered diet. If substantial compliance if found in the weekly and monthly audits, the audit will then be complete. This performance improvement plan will be discussed and evaluated in the QAPI committee meeting monthly and as needed. Any areas of concern will be	

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F 561	Continued From page 4 low potassium diet. The DM further indicated she followed the physician ordered diet first. She revealed the NAs who took the orders for meals were not educated on the diet restrictions. She stated "this is something we need to improve on." An interview with the Registered dietician (RD) on 12/6/17 at 12:45pm revealed Resident #33 preference list is limited due to the decreased potassium needs. She stated they try and balance the physician order with resident request. She further stated with an alert and oriented resident, preference would come first if their diet requirements had been discussed with resident. An interview with the Administrator and the Director of Nursing (DON) on 12/7/17 at 8:08am revealed their expectation was residents get the diet that was ordered by the physician and would accommodate residents request if it's within the ordered diet. The DON stated she expected residents to be sent menu choices of what they could have according to the physician ordered diet and if the residents then changes their mind after receiving it, they can get what they want. The administrator indicated dietary should follow the physician orders as close as possible to what the resident requested. An additional interview with the Dietary manager on 12/7/17 at 2:00pm reported all changes to dietary preferences should go to her as she is the one who can make those changes.	F 561	addressed and corrected immediately.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		1/4/18

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F 656	Continued From page 5 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to develop a care plan 1 of 4 residents (Resident #64) who had an indwelling catheter, utilized a communication book, and had a diagnosis of seizure disorder. The findings included: 1. Resident #64 was admitted to the facility on 5/2/17 with a diagnosis that included muscular dystrophy, spastic hemiplegia affecting left nondominant side, epilepsy, hereditary motor and sensory neuropathy, major depressive disorder, anxiety disorder, fecal and urinary incontinence, and peroneal muscular atrophy. The most recent Minimum Data Set (MDS) assessment dated 10/27/17 revealed Resident #64 required extensive assistance to complete activities of daily living (ADL's), had communication deficit and a diagnosis that included seizure disorder and neurogenic bladder. The MDS assessment further revealed Resident #64 was cognitively intact as evidenced by a brief interview for mental status (BIMS) score of 15. a. Review of Resident #64 care plan revealed no care plan for the use of an indwelling catheter. Review of Resident #64 admission history and physical exam dated 5/5/17 revealed a problem master list that included fecal and urinary incontinence. The history of present illness stated, "He also required Foley catheter placement a few days ago because of a distended abdomen with a large amount of retained urine". The impression/plan indicated Resident #64 had a diagnosis of neurogenic	F 656	F656 This plan of correction will serve as the facility's allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the December 7, 2017 survey and does not constitute an agreement or admission of Clapp's Nursing Center of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of January 4, 2018 Key members of the QAPI committee met to determine the root cause of the citation related to F656 as well as a plan to correct the citation. Upon investigation of all residents with indwelling catheters, Seizure Diagnoses, or use of a communication board, it was found all other care plans were accurate and complete. Due to this investigation and interviews with both MDS Coordinators, it was determined the lack of care plan	

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F 656	Continued From page 7 bladder. Review of Resident #64 care area assessment (CAA) analysis of findings dated 5/12/17 stated Diagnosis of neurogenic bladder present on admission and placement of indwelling catheter is utilized. Monitor for signs and symptoms of infection was implemented daily. Review of Resident #64 initial assessment physician note dated 6/5/17 revealed the resident was been for admission for services. the note revealed a diagnosis of encounter for fitting and adjustment urinary device. The treatment plan stated, "Foley catheter secondary to urinary retention: recent onset and continuous. Resident was treated for urosepsis in 5/2017 secondary to infection from urinary retention with providencia stuartii bacteria noted". Resident was referred to urologist with recommendation to continue with indwelling catheter usage. A diagnosis of neurogenic bladder was provided by physician on 5/31/17. The plan indicated continue with indwelling catheter usage and need for urologist consult as indicted. Staff to maintain indwelling catheter with changes every 4 - 6 weeks or with complications. The note continued with the facility would consider initiation of acetic acid/sterile water flushes as indicated for management of sediment and to start discussion with RP about usage of an indwelling catheter with risk of sepsis/UTI secondary to nursing home residency. Will add cranberry to POC if acceptable to RP for promotion of urinary health. Observation of Resident #64 on 12/4/17 at 12:26pm revealed the resident to be receiving assistance with dining. A covered catheter bag was observed to hanging from the frame of the	F 656	completion was an oversight and was not due a lack of knowledge. As a preventative measure, both MDS Coordinators were re-educated on the clinical areas that must be care planned on 12/27/2017. As stated above, the care plans of all residents with an order for an indwelling catheter, diagnosis of seizures, or use of a communication board were audited for completion. This audit was completed on 12/27/2017 and no areas of concern were found. To ensure the above plan of correction remains effective, any newly admitted resident after 12/27/2017 and any current residents who receive new orders for a catheter, new diagnosis of Seizures or establishes use of a communication board will be care planned accordingly. The DON or designee will be responsible for auditing the care plans for any new order for a catheter, new diagnosis of seizures or newly established use of a communication board. The DON or designee will audit to ensure the MDS Coordinators are completing the care plans accurately in these areas for 3 months. If substantial compliance is found in these audits, the audit will then be transitioned into a quarterly QAPI audit. The QAPI committee will discuss this Plan of Correction during monthly meetings and as needed. If any issues or concerns arise, they will be addressed timely	

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F 656	Continued From page 8	F 656		

resident's bed.

Interview with the Director of Nursing (DON) on 12/7/17 at 9:02am revealed it was her expectation that care plans reflect the resident's disease process.

Interview with the MDS Coordinator on 12/7/17 at 11:12am revealed Resident #64 had a care plan for indwelling catheter use that was initiated on 12/6/17. She revealed the resident was admitted to the facility with a catheter and it should have been care planned upon his admission.

Interview with the Administrator on 12/7/17 at 3:59pm revealed it was his expectation that Resident #64 indwelling catheter be care planned.

b. Review of Resident #64 care plan revealed no care plan for Residents #64 communication sheet.

Review of Resident #64 CAA analysis of findings dated 5/12/17 stated resident was alert, oriented x 3, however he was nonverbal and used a communication sheet to address his needs and answers questions. He was able to nod his head yes and no and would answer with a thumbs up for yes and thumbs down for no. the analysis of findings continued with the social worker interviewed resident #64 on 5/12/17 with the communication sheet and with yes and no questions. The CAA further stated 12/15 on the BIMS as Resident #64 could not pronounce the words due to his aphasia. Resident #64 could communicate his needs daily through his communication sheet which had pictures and words. When he was ready to lay down he points

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F 656	Continued From page 9	F 656		

to the bed. It further stated, "will care pan his communication".

Observation of Resident #64 on 12/6/17 at 7:20am revealed the resident to have a black communication book on his bedside table.

Interview with the DON on 12/7/17 at 9:002am revealed it was her expectation that Resident #64 needs for communication be care planned.

Interview with the MDS Coordinator on 12/7/17 at 11:12am revealed she was unaware Resident #64 utilized a communication sheet/book for a means of communication. She further indicated Resident #64 should have been care planned for his use of a communication device and she was unsure why the residents needs in communication was not developed.

Interview with the Administrator on 12/7/17 at 3:59pm revealed it was his expectation that Resident #64 communication needs be care planned.

c. Review of Resident #64 Care plan revealed no care plan for the diagnosis of epilepsy.

Review of Resident #64 admission history and physical exam dated 5/5/17 revealed a problem master list that included Epilepsy. The medications included Vimpat 200 milligrams (mg) by mouth twice daily and lamotrigine 100mg by mouth every morning (a.m.). The admission history and physical exam further revealed Resident #64 had an allergy to Keppra.

Review of Resident #64 monthly physician note dated 8/10/17 revealed the resident was seen for

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F 656	Continued From page 10 follow up for diagnoses that included epilepsy. The note stated epilepsy, unspecified, intractable, with status epilepticus with medications listed as lamotrigine 100mg table. The goal stated member had no seizure activity on current medication regimen by goal evaluation date. The treatment plan revealed epilepsy secondary to muscular dystrophy was chronic and managed. Resident #64 had an allergy to Keppra. No recent seizure activity and no information in medial record for last reported seizure activity. The note continued with lorazepam in place to be used with onset of seizure activity. The plan was to continue with current plan of care (POC) and m/e for need for titration of POC as indicated to reach/maintain goals. The physician note indicated there was a discussion with responsible party (RP) about usage of medications with side effects; risk and benefits of mediations and they were in agreement with its usage. The medications included vimpat; lamotrigine. Interview with the Director of Nursing (DON) on 12/7/17 at 9:02am revealed it was her expectation that care plans reflect the resident's disease process. Interview with the MDS Coordinator on 12/7/17 at 11:12 am revealed Resident #64 diagnosis of epilepsy should have been care planned. Interview with the Administrator on 12/7/17 at 3:59pm revealed it was his expectation that Resident #64 have a care plan in regard to his diagnosis of epilepsy.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		1/4/18

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F 688	Continued From page 11 §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 observations, resident and staff interviews and record review, the facility failed to apply right hand splint as written by the Director of Therapy for 1 of 1 sampled residents with limited range of motion/contractures (Resident # 56). The findings included: Resident # 56 was admitted to the facility on 7/14/17 with diagnoses that included palmar fascial fibromatosis (a condition in which tissue in the palm of the hand covering the finger tendons thickens and scars contracting the fingers inwards toward the palm). A review of the most recent MDS (Minimum Data Set) dated 10/09/17, had documentation of Resident # 56 being assessed as having intact	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 December 7, 2017 survey and does not constitute an agreement or admission of Clapp's Nursing Center of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this	

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F 688	Continued From page 12 cognition. The assessment was coded as resident having functional impairment with limited mobility of bilateral upper extremities. A review of the care plan with a problem onset dated 9/07/17, included nursing to don both upper extremity hand splints 8 hours daily as tolerated due to risk of worsening contractures. A review of the documentation by the Director of Therapy dated 9/07/17 revealed nursing had been notified for the care plan to reflect BUE (bilateral upper extremities) hand splints to be worn 8 hours daily or to patient tolerance. The Skilled Services Provided section revealed training had been completed with nursing for carryover of training in how to donn and doff the BUE splints to decrease the risk of worsening contracture. The document read: Patient at this time is able to transition to nursing care for splint application. The treatment diagnosis listed right hand contracture, left hand contracture, and pain in the right hand. During a review of the resident's physician orders, an order dated 8/28/17 read: Place resting hand splint to left hand at hs (hour of sleep) and remove every AM (morning). No other orders were written to reflect BUE hand splints to be worn hours 8 daily or to patient tolerance since the discharge summary of the Director of Therapy and care plan had been updated on 9/07/17. An interview on 12/07/17 at 3:26 PM with Nurse # 8 revealed the nurse who wrote the order for Resident # 56 to wear a left hand splint and left off the order for the right hand splint. The nurse who wrote the order no longer worked in the facility.	F 688	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 January 4, 2018. Key members of the QAPI Committee met to determine the root cause of the citation related to F688 and to develop and implement a new procedure for following splinting recommendations from our Therapy Department. After investigation, it was determined the reason the splint was not donned on the resident was due to the splint use recommendation not being transcribed on to the Treatment Record. This caused the floor staff to be unaware of the splinting recommendations. In order to correct the deficient practice, a new procedure has been implemented to ensure compliance. Under the new procedure, when a therapist writes a recommendation for a splint to be donned and doffed by nursing staff, a recommendation form is given to the MDS Coordinators. They are then responsible for care planning the splint use and scheduling the donning/doffing instructions of the splint on the Treatment Record. By scheduling the splint on the treatment record, floor staff will then be notified of the new recommendation automatically just as when a new medication is added to the Medication Record. The MDS Coordinators were educated on their responsibilities on 12/27/2017. To ensure on-going compliance of the	

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F 688	Continued From page 13 Observations on 12/04/17 at 11:37 AM, 12/05/17 at 3:58 PM, and 12/06/17 at 7:59 AM, revealed bilateral hand splints were placed on the nightstand in the room for Resident # 56. In an interview on 12/05/17 at 3:58 PM, Resident # 56 stated the splint for her left arm was worn at night. She continued to explain the right hand splint was supposed to be worn during the day but the staff had been too busy because they had been short-staffed and she did not want to bother them. An interview on 12/06/17 at 8:00 AM was conducted with NA (Nursing Assistant) # 2 who stated Resident # 56 had a slightly contracted right hand. She continued to explain a splint had been worn during the day but was stopped because of a cream applied during the day. The splint is now worn at night and taken off before the third shift nurse goes home. She added that only nurses have orders related to splints and the nurse would verbally communicate to the NA any special considerations. An interview on 12/07/17 at 6:52 AM was conducted via telephone with Nurse # 7. Nurse # 7 indicated she removed the splint to the left hand at the end of her shift each morning. She explained the right arm brace was not worn at night. An interview on 12/07/17 at 9:50 AM with the MDS Coordinator revealed care plans were put together by her department after receiving communication from the therapy department. The MDS Coordinator stated she was responsible for care plans to match the orders. She	F 688	new splint recommendation protocol, five residents will be observed per week x 4 weeks by the Director of Nursing or designee to ensure their splints are on at the recommended times. If substantial compliance is found during this audit, the audit will then be reduced to monthly. During these monthly audits, the Therapy Manager and Director of Nursing will round the building and evaluate all residents with splint recommendations. During these rounds the Therapy Manager and Director of Nursing will ensure the splints are being used appropriately and accurately. They will also be assessing the effectiveness of the splint as well. The Director of Nursing will be responsible for ensuring this new procedure is implemented correctly and continues to remain successful. The QAPI committee will discuss the success of this audit in the Monthly QAPI meeting and as needed. Any areas of concern will be addressed and corrected immediately. Substantial compliance related to F688 will be achieved by 01/04/2018	

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F 688	Continued From page 14 explained it was the MDS Coordinator's responsibility to ensure orders match the care plan. An interview on 12/07/17 at 10:50 AM with the Administrator revealed he was not aware staff had not applied the right hand splint for Resident # 56. He stated his expectation was for the care plan to reflect the resident's orders. An interview on 12/07/17 at 3:10 PM with the MDS Coordinator revealed the order for the right hand splint was reviewed and the nurse on the unit was handed the discharge summary from OT (Occupational Therapy) on 9/07/17. She wrote the order for the left hand splint and did not write the order for the right hand splint.	F 688		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		1/4/18

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F 880	Continued From page 15 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 16 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of the facility policy, the facility failed to ensure nursing staff performed hand hygiene after removing gloves during a dressing change for three separate wound sites and failed to disinfect the scissors used during the treatment for 1 of 1 resident (Resident # 38) and failed to wash hands between touching residents and prior to touching the end of straws residents used for consumption of fluids and while passing meal trays during 1 of 2 meal observations for 3 resident rooms on hall 700 (resident rooms #709 bed A and Bed B, 710 and 703). Findings included: 1. A review of the facility's policy entitled, "Skin and Wound Management," adopted from the Nursing Services Policy and Procedure Manual for Long-Term Care 2001 MED-PASS, Inc. with a revision date of September 2013, revealed to wash and dry hands thoroughly each time before putting on clean gloves. Resident # 38 was admitted on 3/18/17 and readmitted to the facility on 11/19/17 with a diagnosis that included bacteremia, MDRO (Multidrug-Resistant Organism), infection of the left great toe related to osteomyelitis and status post amputation, and diabetes mellitus.	F 880	F880 This plan of correction will serve as the facility's allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to DHHS 2567 for the December 7, 2017 survey and does not constitute an agreement or admission of Clapp's Nursing Center of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of January 4, 2018 To determine the root cause of being cited for F880, key members of the QAPI Committee met to discuss our current procedures for educating and monitoring	

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F 880	Continued From page 17 A review of the most recent MDS (Minimum Data Set) dated 11/26/17, coded as an admission assessment, had documentation of Resident # 38 needing extensive assistance with activities of daily living, and as having a surgical incision and diabetic ulcers. An observation on 12/06/17 at 10:24 AM, revealed Nurse # 6 had not washed her hands after taking off dirty gloves used to remove the soiled dressing for a surgical site and continued to treatment. The nurse did not wash her hands again after taking off two other soiled dressings for 2 diabetic ulcers for Resident # 38. After the dressing was completed it was observed that Nurse # 6 did not decontaminate the scissors used before placing it into her pocket. In an interview on 12/06/17 at 10:40 AM, Nurse # 6 stated she did not wash her hands after taking off her dirty gloves before putting on clean gloves throughout the dressing change for Resident # 38. Nurse # 6 continued to explain she had forgotten to clean the scissors used during the dressing treatment. In an interview on 12/07/17 at 11:13 AM, the SDC (Staff Development Coordinator) stated her expectation and what she trained staff was to wash your hands with soap and water anytime you removed your gloves. She explained during a wound care dressing change, the nurse should wash hands before taking off an old dressing, then remove gloves, wash your hands with soap and water, and then put on new gloves to proceed with wound care treatment. The SDC revealed the scissors used during a dressing change should be cleaned with a wipe from the	F 880	for infection control protocols. After discussion and interviews with the two employees described in the Statement of Deficiencies, the committee concluded the facility's current protocols for educating and monitoring for infection control was more than sufficient. The root cause of the events listed in the statement of deficiencies was nervousness for both Nurse #6 and Nurse Aid #9. Both employees were educated upon hire of infection control protocols and both employees have been educated annually at minimum since hire. Both employees recently attended a skills fair at the facility in which infection control and hand hygiene were a focus and return demonstration was required for staff participating. In order to ensure all required staff were aware of infection control protocols, all nurses will be re-educated by January 4th, 2018 related to proper infection control procedures when performing dressing changes. All nursing staff will be re-educated by January 4th, 2018 related to proper hand hygiene specifically related to passing trays and tray set-up. The facility already has a QAPI audit in place for observing dressing changes which is done on a quarterly basis. Due to the citation and in order to ensure compliance on going, two dressing changes will be observed per week x 4 weeks by the QA Coordinator or designee to ensure the nurses follow proper infection control protocols are followed. If substantial compliance is found the audit will be reduced to two dressing changes	

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F 880	Continued From page 18 purple container (Germicidal Wipe) after the dressing change and before placed into a scrub pocket. An interview was conducted on 12/07/17 at 11:57 AM with the Assistant Administrator who stated it was her expectation that hands were to be washed after each time gloves were removed before putting on new gloves. The Assistant Administrator revealed Nurse # 6 had spoken to her about the occurrence and had told her she was just nervous and forgot. The Assistant Administrator continued to indicate that the scissors used during the dressing change should have been cleaned with a germicidal wipe after the dressing change before placed in her scrub pocket. An interview was conducted on 12/07/17 at 12:15 PM with the Administrator. He stated his expectation was for staff to clean their hands after removing gloves in any situation. He continued to reveal the scissors used during a dressing change should be cleaned before placed in the nurse's scrub pocket. 2. Review of facility policy titled, "Handwashing/Hand Hygiene" (revised August 2015) stated the facility considered hand hygiene the primary means to prevent the spread of infections. The policy interpretation and implementation included (2) all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. (3) hand hygiene products and supplies (sink, soap, towels, alcohol-based hand rub, ect.) shall be	F 880	per month x 3 months. If no areas of concern are found during the monthly audit, the audit will then resume to the original QAPI quarterly audit on-going. The QA Coordinator or designee will also audit 5 Nurse Aides per week at meal time for 4 weeks to ensure proper hand hygiene and infection control protocols are followed. If substantial compliance in this audit is found, the audit will then be reduced to 5 Nurse aides per month x 3 months. The QAPI committee will discuss the progress and results of this Plan of Correction monthly and more often if needed. Any areas of concern will be addressed accordingly by the appropriate committee members.	

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F 880	Continued From page 19	F 880		

readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. (7) use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b) before and after direct contact with residents; (l) after contact with objects (e.g., medical equipment) in the immediate vicinity of the residents; (o) before and after eating or handling food (p) before and after assisting a resident with meals.

A continuous observation was conducted of meal service for hall 700 on 12/14/17 at 12:01pm through 12:20pm.

a. Nursing assistant (NA) #9 was observed to enter room #709 and begin tray set up for bed B. NA#9 removed corn bread from its white paper packaging and placed the cornbread in her hands. She was further observed to remove silver wear from its white paper packaging and held the eating utensils with her hands. The bedside table was positioned in front of the resident. NA#9 physically touched the straw on both ends while removing the paper and placed the straw in the resident's fluids.

b. NA#9 was observed to exit resident room #709, return to the meal cart located on the hall and retrieved resident meal tray for room #709 bed A. NA#9 was observed to position the resident's bedside table directly in front of the resident. NA#9 removed two straws from their original packaging and touched the end of the straws before placing them into the resident's fluids. NA#9 was observed to exit room #709 and return to the meal cart.

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c. NA#9 retrieved the meal tray for resident room #710 bed A. She was observed to directly touch the resident's silverware with her hands.

d.NA#9 was observed to retrieve meal tray for resident room #703 bed A. The resident was assisted with donning a clothing protector and NA#9 adjusted the resident's bedside table height. NA#9 removed the resident's silverware from its white paper packaging and held the eating utensils with her hands. Further observed revealed NA#9 to open drinks and spread butter on the resident's bread. At 12:13pm the resident in room #703 was assisted by NA#9 with dining. Observations from 12:01pm through 12:20pm revealed NA#9 to not wash her hands between touching residents, adjusting bedside tables, touching silver wear, straws or prior to assisting a resident with dining.

Interview with NA#9 on 12/4/17 at 12:50pm revealed she did not wash her hands between resident's meal tray set up. She stated the she did not have any hand sanitizer on her person. She further indicated she should have washed her hands or sanitize her hands when exiting the rooms and between meal set-up.

Interview with the Administrator on 12/7/15 at 4:25 pm indicated his expectation was for staff to wash hands between touching residents and meal tray set up.