STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. BUILDING _____ B. WING _____	C 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT BOTETOURT COMMONS	290 COMMONS PARKWAY DALEVILLE, VA 24083

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/7/17 through 2/9/19. Complaints were also investigated. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 76 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Resident #1 through Resident #13) and 3 closed record reviews (Resident #14 through Resident #16).	F 000		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278		3/24/17

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

Electronically Signed | 02/23/2017

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F 278	Continued From page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate Minimum Data Set (MDS) for 1 of 16 residents (Resident #10). The findings include: The facility staff failed to include an active diagnoses of dementia with behavioral disturbance on the annual MDS with a reference date of 10/28/16. Resident #10 was admitted to the facility on 9/17/15 with diagnoses of anemia, atrial fibrillation, congestive heart failure, coronary artery disease, anxiety, depression, urinary tract infection, chronic obstructive pulmonary disease, and dementia with behavioral disturbance. The annual MDS with a reference date of 10/28/16 assessed the resident with a cognitive score of "0" of "15". The resident was assessed requiring extensive assistance of 2 persons for bed mobility, transfers, dressing, toileting,	F 278	Resident #10 MDS with ARD 10/28/16 was corrected 2/8/17 to reflect the diagnosis dementia with behavioral disturbance. An audit of section "I" for active diagnosis was completed for the most recent MDS assessments for other current resident and corrections were made as applicable on 2/17/17. An in-service was completed with the IDT to include accurate completion and coding of sections on 2/8/17 per assigned disciplines according to the RAI guidelines. The MDS coordinators or designees will audit a minimum of two (2) completed MDS assessments for accuracy weekly for eight (8) weeks. Findings of such audits will be reported to the QA committee who will determine the	

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F 278	Continued From page 2 bathing, and hygiene. The clinical record was reviewed. The physician had documented on the progress notes that one of the resident's diagnoses was dementia with behavior disturbance. The progress note dated 10/17/16 noted the resident with a diagnosis of dementia with behavior disturbance. The annual MDS with a reference date of 10/28/16 was reviewed. The Section "I" for Active Diagnoses did not contain a diagnosis of dementia with behavior disturbance. The resident was being treated with the antipsychotic medication, Seroquel. The MDS co-ordinator (RN#3) was asked on 2/8/17 about the diagnosis and stated a correction would be done. The administrator, director of nursing and corporate nurse consultant were informed of the finding during the end of the day meeting with the survey team on 2/8/17.	F 278	needs or duration of future audits.	
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.	F 280		3/24/17

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F 280	Continued From page 3 (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (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--	F 280		

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F 280	Continued From page 4 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for 1 of 16 residents (Resident #6). The findings include: The facility staff failed to review and revise the comprehensive care plan for Resident #10.	F 280	Resident #6 care plan was corrected 2/8/17 with Diabetes Mellitus removed. Labs per order were added to Seroquel care plan 2/8/17. An audit of all current residents care plan was completed for accuracy of diagnosis 2/17/17. An in-service was completed 2/8/17 with	

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F 280	Continued From page 5 Resident #10 was admitted to the facility on 9/17/15 with diagnoses of anemia, atrial fibrillation, congestive heart failure, coronary artery disease, anxiety, depression, urinary tract infection, chronic obstructive pulmonary disease, and dementia with behavioral disturbance. The annual Minimum Data Set (MDS) with a reference date of 10/28/16 assessed the resident with a cognitive score of "0" of "15". The resident was assessed requiring extensive assistance of 2 persons for bed mobility, transfers, dressing, toileting, bathing, and hygiene. The clinical record was reviewed. The comprehensive care plan included a problem listed the resident had diabetes with an initial start date of 10/28/16. The goal stated the resident's diabetes would be controlled by diet, oral hperglycemics, and insulin through the next review. The resident did not have a diagnosis of diabetes. The MDS coordinator (RN#3) was interviewed on 2/8/17 at 9:00 a.m. and asked about the diagnosis of diabetes. The director of nursing informed the surveyor the resident was on an antipsychoitc medication, Seroquel, and this was the reason the resident was being followed for laboratory studies (Hemoglobin A1C) to monitor blood sugar readings. The director of nursing stated the resident did not have a diagnosis of diabetes. The administrator, director of nursing and corporate nurse consultant were informed of the finding during the end of the day meeting with the survey team on 2/8/17.	F 280	the IDT to include accurate care planning per assigned disciplines. The MDS coordinators or designees will audit a minimum of two (2) completed care plans for accuracy weekly for eight (8) weeks. Findings of such audits will be reported to the QA committee who will determine the need or duration of future audits.	

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F 514	Continued From page 6	F 514		
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (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 (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 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:	F 514		3/24/17

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F 514	Continued From page 7 Based on resident interview, family interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure a complete and accurate record for 4 of 16 residents (Resident #5, Resident #7, Resident #8, and Resident #14). The findings included: 1. The facility staff failed to document the reason Resident #5 received a prn (whenever necessary) Xanax on 2/3/17 at 2:03 a.m. The clinical record of Resident #5 was reviewed 2/7/17. Resident #5 was admitted to the facility 10/17/14 with diagnoses that included but not limited to hypertension, encephalopathy, pain, anxiety, depression, ataxic gait, insomnia, conjunctivitis, osteoporosis, diastolic heart failure, acute upper respiratory infection, and hypoxemia. Resident #5's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/3/17 assessed the resident with a cognitive summary score of 15 and without signs or symptoms of delirium or psychosis. Resident #5 was assessed to have verbal behavioral symptoms directed at others 4-6 days a week but not daily. Resident #5 was assessed to have rejected care 1-3 days during the look back period. The current comprehensive care plan dated 1/10/17 identified Resident #5 had difficulty in making decisions at times related to impaired cognition and anxiety. Approaches included in part to approach resident warmly, give one instruction at a time, offer simple choices to resident, and provide activities that require only	F 514	Resident #5 documentation for Xanax PRN use was unable to be corrected. License nurse #4 was re-educated 2/9/17. Facility QAPI Five Point Plan of correction dated 1/17/17 continues to be monitored. Resident #7 Insulin MAR was unable to be corrected. License nurse #5 completed a late entry nurses note on 2/8/17. License nurse #5 was re-educated on Insulin MAR documentation on 2/8/17. Resident #8 RP was called on 2/17/17. A complete chart review of all significant changes and falls was completed from admit date 9/20/16 to current. Resident #14 discharge documentation was unable to be corrected. License nurse #1 was re-educated on discharge documentation policy 2/9/17. Nursing administration completed an audit of current in-house residents PRN medication use for assessment intervention and documentation on 2/17/17. Nursing administration completed an audit of current in-house residents Insulin MAR for accurate completion on 2/17/17. Nursing administration completed an audit of current in-house residents for any falls and RP notifications in the last 90 days on 2/17/17. Nursing Administration completed an audit	

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short attention span for completion. A second care plan focused on Resident #5's altered thought processes and approaches included to try to redirect resident as appropriate behaviors and to document resident behaviors.

Resident #5's February 2017 physician order sheet included the following order that read "Xanax 1 mg (milligram) by mouth two times a day as needed Order Date: 10/23/14 Start date: 10/23/14 ALPRAZOLAM F 41.9 Anxiety disorder, unspecified."

The surveyor reviewed the February 2017 electronic medication record. Resident #5 was administered Xanax 1 mg on 2/3/17 at 2:03 a.m. by licensed practical nurse #4. The surveyor reviewed the 2/3/17 departmental notes and found a note dated 2/3/17 at 3:27 a.m. and written by L.P.N. #4 that read "CONT. (continues) ON ABT (antibiotic) FOR SINUSITIS. VS (vital signs) T. (temperature) 98.3 P (pulse) 60 R. (respirations) 18 B/P (blood pressure) 123/57 O2 SAT (oxygen saturation) 93%. O2 ON VIA NC (nasal cannula) @ (at) 2 L (liters). RESTING QUIETLY."

The reason for the administration of Xanax to Resident #5 had not been documented in the departmental notes on 2/3/17.

The surveyor informed the administrator and the director of nursing of the above issue on 2/8/17 at 3:55 p.m. The director of nursing stated she had identified an issue with psychotropic medications and had developed a quality improvement plan for those medications.

The director of nursing (DON) provided the

of discharge home documentation in the last 30 days on 2/17/17.

In-services were initiated 2/13/17 and will be provided to license nurses to include:
* Policy and procedure on PRN medication assessment, interventions and documentation.
* Policy and procedure on diabetic monitoring and documentation on Insulin MAR.
* Policy and procedure on charting documentation, change in status, and RP notification.
* Policy and procedure on discharge documentation.

The Nursing Administration team will audit nurses notes, EMAR, Insulin MAR and discharge documentation three (3) times a week for eight (8) weeks.

Findings of such audits will be reported to the QA committee who will determine the need or duration of future audits.

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surveyor with a copy of the "Five Point Plan of Correction" dated 1/17/17 on 2/9/17. The in-service/education record dated 1/18/17 read in part "Remember prior to administering any PRN medication please assess root of behavior-what is possibly wrong and attempt non-pharmacological intervention prior to medicating. DOCUMENT YOUR INTERVENTIONS IN NN (nurses notes)." L.P.N. #4 had signed the in-service/education record.

The DON stated the nurse who didn't document the reason Xanax was administered to Resident #5 will be re-educated.

The surveyor reviewed the facility policy on "Charting and Documentation" on 2/9/17. The policy read in part "6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: c. The assessment data and /or any unusual findings obtained during the procedure/treatment."

No further information was provided prior to the exit conference on 2/9/17.

2. The facility staff failed to document blood sugar results in the clinical record for Resident #7.

The surveyor reviewed Resident #7's clinical record on 2/8/17. Resident #7 was admitted to the facility 11/19/10 and readmitted 1/20/17 with diagnoses that included but not limited to Type 2 diabetes mellitus, end stage renal disease (ESRD) with dialysis, major depressive disorder, peripheral vascular disease, hyperlipidemia, hypothyroidism, gastroesophageal reflux disease,

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pain, adult failure to thrive, bilateral below the knee amputations, benign prostatic hypertrophy, and urethral disorder.

Resident #7's 5 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/27/17 assessed the resident with a cognitive summary score of 8 out of 15. Resident #7 was without delirium, psychosis, or behaviors.

Current comprehensive care plan dated 1/27/17 identified Diabetes as a problem. Approaches: Accuchecks as ordered.

The surveyor reviewed the February 2017 physician order sheet. Resident #7 had orders for accuchecks before meals and at bedtime and to notify MD (medical doctor) for BG (blood glucose) < (less than) 60 or > (greater than) 450.

The surveyor reviewed the February 2017 electronic insulin medication administration record (eINSULIN MAR). The accuchecks for 2/2/17 at 4:30 p.m., 2/2/17 at 9:00 p.m., and 2/4/17 at 9:00 p.m. read low. There were no blood sugar results documented on the eINSULIN MAR.

The surveyor reviewed the 2/2/17 and 2/4/17 departmental notes and found no documented blood sugar results.

The surveyor informed the administrator and the director of nursing of the above documentation concern on 2/8/17 at 3:55 p.m.

The director of nursing reviewed the information provided by the surveyor and informed the surveyor the licensed practical nurse was a new

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employee. The DON stated she may have kept her "paper" documentation for the blood sugars. The surveyor interviewed licensed practical nurse #5 on 2/8/17 at 4:10 p.m. L.P.N. #5 provided the surveyor with paper documentation of blood sugars obtained 2/2/17 and 2/4/17. L.P.N. #5 apologized to the surveyor and repeatedly stated she was new.

The DON stated L.P.N. #5 would be re-educated on documentation on the electronic medication record.

The surveyor reviewed the facility policy on Diabetes-Clinical protocol on 2/9/17. The policy read in part "Monitoring and Follow-Up 4. The physician will order desired parameters for monitoring and reporting information related to diabetes or blood sugar management. a. The staff will incorporate such parameters into the Medication Administration Record and care plan."

No further information was provided prior to the exit conference on 2/9/17.

3. The facility staff failed to document when the responsible party for Resident #8 was notified of a fall.

The clinical record of Resident #8 was reviewed 2/8/17. Resident #8 was admitted to the facility 9/20/16 with diagnoses that included but not limited to hypothyroidism, hypertension, hypokalemia, pain, anemia, major depressive disorder, Alzheimer's disease, gastroesophageal reflux disease, pressure ulcer right hip, stage 4, cognitive communication deficit, and psychotic disorder with hallucinations.

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Resident #8's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/6/17 assessed the resident with a cognitive summary score of 10 out of 15 and without signs or symptoms of delirium, psychosis or behaviors. Resident #8 was assessed to need extensive assistance of one person for bed mobility, transfers, and toileting and total dependence on two people for bathing. Resident #8 had no impairment in either upper extremities or lower extremities. Resident #8 did not have any falls coded in the look back period.

Resident #8's current comprehensive care plan dated 1/6/17 identified a potential problem of falls. Approaches included to involve resident and responsible party in POC (plan of care). Notify MD (medical doctor) and responsible party of falls and any fall related injury.

The clinical record contained a nursing communication form dated 11/24/16 that read "Got out of her w/c (wheelchair) & observed seated on floor. Rsd (resident) said she wanted to go to her room-denied pain injury (sic). 97.6, 82, 18, 122/58." The form had been faxed to the MD on 11/24/16 and the physician responded on 11/25/16 with "ok." The departmental note for 11/24/16 6:26 p.m. read "97.6, 82, 18, 122/58 90%. At 7:20 p.m., got out of wc (wheelchair) near nurses station & was observed seated on the floor in front of her wc. Denied injury or pain, said she was going to her bed. Assisted to her feet & back into her wc & brought to her room & put to bed by her C.N.A. (certified nursing assistant). Much encouragement given to stay in her w/c and let nsg (nursing) staff assist her."

The departmental note had no documentation

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	495386	A. BUILDING _____ B. WING _____	C 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT BOTETOURT COMMONS	290 COMMONS PARKWAY DALEVILLE, VA 24083

(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
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that the responsible party had been informed of the fall.

The surveyor informed the assistant director of nursing (ADON) of the concern that Resident #8's responsible party had not been notified of the fall on 11/24/16 on 2/8/17 at 1:45 p.m. The ADON reviewed the facility investigation and stated there was no documentation that the RP had been notified.

The surveyor informed the administrator and the director of nursing of the above concern on 2/8/17 at 3:55 p.m. The surveyor requested the facility policy on notification. The DON stated the policy doesn't specify notification of the responsible party if there were no injuries but she would expect the responsible party to be notified.

The surveyor interviewed the responsible party (RP) on 2/8/17 at 9:44 a.m. The RP was asked if the staff notified him of medication changes, falls, or a change in condition. The RP stated they notified him about everything.

The surveyor informed the administrator and the director of nursing of the lack of documentation when Resident #8's RP was notified of the resident's fall on 11/24/16 in a meeting on 2/9/17 at 10:45 a.m.

No further information was provided prior to the exit on 2/9/17.

4. The facility nursing staff failed to document when Resident #14 was discharged.

The surveyor reviewed the clinical record of Resident #14 on 2/8/17 and 2/9/17.

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Resident #14 was admitted to the facility 10/4/16 with diagnoses that included but not limited to fractured right hip, urinary tract infection, dehydration, hypothyroidism, iron deficiency anemia, diaphragmatic hernia without obstruction or gangrene, vascular dementia without behavioral disturbances, bilateral hearing loss, blindness, right eye, low vision left eye, insomnia, and symbolic dysfunction.

Resident #14's 5 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/11/16 assessed the resident with a brief interview for mental status as 0 out of 15. Resident #14 was without any signs or symptoms of delirium, psychosis, or behaviors. Resident #14 was assessed with hearing impairments-absence of useful hearing. Resident #14 did not have use of a hearing aid. Resident #14's speech was unclear with slurred or mumbled words, sometimes understood others and sometimes made herself understood. Resident #14 was highly impaired visually-object identification in question, but eyes appear to follow objects. Resident #14 wore corrective lenses. Resident #14 required extensive assistance of 2 people for bed mobility, transfers, toileting, and personal hygiene. Resident #14 was assessed with impairment to the lower extremity that affected one side only. Mobility devices for Resident #14 were assessed to be a wheelchair and walker. Resident #14 was assessed to be frequently incontinent of bowel and bladder.

The interim admission care plan initiated 10/4/16 and revised 10/5/16 identified areas of self-care for ADLs (activities of daily living), alteration in elimination, at risk for falls, and potential for pain.

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The interim care plan also included a section for orientation to environment.

The 10/12/16 departmental notes did not reflect how Resident #14 was discharged from the facility. The 10/12/16 4:42 p.m. note read "Patient discharged with caregiver and personal belongings." The note did not document how the resident left the facility.

The surveyor interviewed the writer of the 10/12/16 4:42 p.m. note on 2/9/17 at 10:30 a.m. The admission director stated she recalled Resident #14 left with a caregiver. The caregiver pulled the white car up to the front doors. The resident was in a wheelchair. The admission director stated the caregiver liked her but that the caregiver was unhappy that day. The admission director stated to get the resident out of the system, a discharge note had to be written.

The surveyor interviewed the director of nursing on 2/8/17 at 8:25 a.m. The director of nursing stated when residents are discharge, a note would be written.

L.P.N. #1 stated when residents are discharged, they are taken in a wheelchair, if it is during business hours, and assisted into their care by staff and rehab. The nurses would document how and when the resident left.

The surveyor called licensed practical nurse #3 on 2/9/17 at 11:21 a.m. L.P.N. #3 stated the family wasn't being very nice that day. L.P.N. #3 stated she collectively remembered that the family escorted the resident to the car. L.P.N. #3 stated she usually wrote a note when residents were discharged.

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F 514	Continued From page 16 The surveyor informed the administrator and the director of nursing of the above documentation concern on 2/9/17 at 10:45 a.m. No further information was provided prior to the exit conference on 2/9/17.	F 514		