DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495328	A. BUILDING ______ B. WING ______	C 09/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE OF TAPPAHANNOCK	1150 MARSH STREET TAPPAHANNOCK, VA 22560

(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 9/11/17 through 9/13/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #1 through #12) and 3 closed record reviews (Residents #13 through #15).	F 000	This plan of correction constitutes our Credible Allegation of Compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared solely because it is require by the provision of federal and state laws.	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed, for 1 resident (Resident #7) of the survey sample of 15 residents, to follow the professional standards of practice for documentation of medication administration. The facility stated that Lippincott was utilized as the basis for professional nursing practice. For Resident #7, the facility staff failed to document the administration of medication 8 times during the month of December, 2016.	F 281	1. The physician and responsible party were notified of the omissions for Resident #7. No further recommendations from physician were given. There were no adverse affects on this resident. 2. An audit was completed on 9/15/2017 of all resident MARS/TARS for the months of August and September 2017 with no other omissions noted. 3. A medication administration in-service was conducted for nurses. The DON and/or designee will audit a minimum of five residents MAR/TAR records five times a week for sixty days.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joseph Hopkins
TITLE: Executive Director
(X6) DATE: 9/22/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1	F 281		

The Findings included:

Resident #7 was a 91 year old who was admitted to the facility on 8/12/16. Resident #7's diagnoses included Psychotic Disorder with Delusions, Alzheimer's Disease, and Muscle Weakness-Generalized.

The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 8/10/17, coded Resident #7 as having a Brief Interview of Metal Status Score 3, indicating severely impaired cognition.

On 9/13/17 a review was conducted of Resident #7's clinical record, revealing the following signed physician's orders:
"December 1, 2016. Depakote 1 Tablet By Mouth Daily at Bedtime. Aricept 1 Tablet By Mouth at Bedtime. Trazodone 1 Tablet By Mouth at Bedtime."

The Medication Administration Record (MAR) was reviewed. The following medications were not documented as having been administered:

Depakote 12/19/16, 12/30/16 at 10:00 P.M.
Aricept 12/7/16, 12/19/16, 12/30/16 at 10:00 P.M.
Trazodone 12/7/16, 12/19/16, 12/30/16 at 10:00 P.M.

The nursing notes were reviewed for December, 2016. There was no documentation of medication administration.

A review of facility documentation was conducted, revealing an "Administering Medications Policy"

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

5. Compliance date: 09/30/2017.

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F 281	Continued From page 2 revised December, 2012. It read: "The individual administering the medication must initial the resident's Medication Administration Record (MAR)on the appropriate line after giving each medication and before administering the next ones." On 9/13/17 at 10:00 A.M. an interview was conducted with the Director of Nursing (DON Administration B). When asked about the facility's expectation regarding documentation of medication administration, she stated, "I expect them to sign the MAR as they give the medication." Guidance was given by Lippincott: "Document all medications administered in the patient's MAR or EMAR. If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions. " Lippincott Solutions, Safe Medication Administration Practices, General" 10/02/2015. On 9/13/17 at 10:30 A.M. the facility Administrator (Administration A), and DON (Administration B) were notified of the findings. No further information was received.	F 281		
F 463 SS=D	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area -	F 463	1. Call bell for Resident # 3 was repaired and placed within resident reach. 2. Audit of all call lights in facility to ensure proper operation and placed within residents reach.	

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F 463 Continued From page 3

(2) Toilet and bathing facilities.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, and in the course of a complaint investigation, the facility staff failed to ensure that the call system was operable in Resident #3's room.

For Resident #3, the facility staff failed to ensure that his call bell was operable.

The Findings included:

Resident #3 was a 77 year old who was admitted to the facility on 6/6/17. Resident #3's diagnoses included Diabetes Mellitus, Hypertension, and Cardiovascular Accident.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 8/9/17, coded Resident #3 as having a Brief Interview of Mental Status Score of 3, indicating that he was severely, cognitively impaired.

On 9/11/17 at 6:30 P.M. a tour was conducted of the facility. Resident #3 was overheard loudly stating, "Nurse! Nurse!". The call bell light was not on in the hallway outside his room (133 A). Upon entering his room, his call bell was observed to be on the floor, out of reach. The call bell was tested by the surveyor, who noted that it was not working. The call light did not come on outside his door. About 5 minutes later a Certified Nursing Aide came into the room (CNA-A). When asked why she had come in, she stated that she wanted to feed Resident #3. When asked why the call bell was not within Resident#3's reach, she

F 463

3. In-service conducted to staff regarding call bell placement. An audit of six rooms five times per week to be conducted by maintenance and/or designee for sixty days.

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

5. Compliance date: 09/30/2017.

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F 463	Continued From page 4 stated, "I have no idea why it is not near him. They could be having an attack or something and no one is around." On 9/13/17 at 9:10 A.M. an interview was conducted with he Maintenance Director (Administration C). He stated that he had just replaced the call bell pendent in room 133 on 9/12/17. He stated that he replaced it because it wasn't working. The Administrator (Administration - A) and Director of Nursing (DON Administration -B) were notified of the findings. No further information was received.	F 463		