| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495386 | A. BUILDING _____ B. WIN_G _____ | C 01/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **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) | (XS) COMPLETION DATE |
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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 1/16/18 through 1/18/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey. | E 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 and/or executed solely because it is required by the provision of federal and state laws.** | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 1/16/18 through 1/18/18. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. The Life Safety Code survey/report will follow.<br><br>The census in this 60 certified bed facility was 89 at the time of the survey. The survey sample consisted of 19 current Resident reviews and 3 closed record reviews. | F 000 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(8) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). | F657 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mitchell P. Dain | TITLE: Executive Director | (XS) DATE: 2/14/18

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 657 | Continued From page 1<br>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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, resident interview, observations, and clinical record review, the facility staff failed to review and revise the comprehensive person centered care plan for 3 of 22 residents in the survey sample (Residents #52, 54, and 28).<br><br>The findings included:<br>1. The facility staff failed to review and revise the comprehensive person centered care plan for Resident #52.<br>Resident #52 was admitted to the facility on 5/29/17 with the following diagnoses of, but not limited to anemia, chronic obstructive pulmonary disease, respiratory failure, anxiety disorder, depression and seizure disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/17/17, the resident was coded as requiring limited assistance of 1 staff member for dressing, personal care and bathing. Resident #52 was also coded as having a BIMS (Brief Interview for Mental Status) of a 15 out of a possible score of 15. | F657 | Resident #52 care plan was updated on 1/17/2018 to include only licensed nurses to adjust her oxygen settings and not resident.<br><br>Resident #54 care plan was updated on 1/18/2018 for nectar thickened liquids.<br><br>Resident #28 care plan was reviewed with resident and appropriate IDT, including all required departments and MD/provider on 2/9/2018 with care plan meeting signature log completed.<br><br>Resident #28 care plan was updated 1/18/2018 to include appropriate dietary care plan.<br><br>An audit of current care plan problems and interventions was completed for all in-house residents and corrections were made as applicable 2/1/2018.<br><br>An audit of care plan meeting signatures was completed 2/1/2018.<br><br>An in-service was completed with the IDT to include:<br>- Accuracy of person centered care plans including problems, goals and interventions.<br>- Accuracy of completion of care plan signature log including all members of IDT including RN, CNA, dietary and physician/provider<br>IDT and /or nursing administration will audit a minimum of three care plans for accuracy of problems/interventions and care plan meeting signature log weekly for eight weeks.<br><br>Findings of such audits will be reported by nursing administration to the QA committee who will determine the need or duration of future audits. | 3/3/2018 |

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| F 657 | Continued From page 2<br>The surveyor went into the resident's room at 12:21 pm on 1/17/18 and observed the resident's oxygen concentrator was setting on 2 ½ liters/minute by nasal cannula. The surveyor and Corporate Nurse #1 went back into room at 1 pm and the oxygen concentrator was set at 2 1/2 liters/minute. Both reviewed the MD orders and the MD orders stated that the O2 concentrator was to be set at 3 liters/minute.<br><br>01/17/18 04:25 pm the administrative team meeting consisted of the Administrator, Director of Nursing and Corporate Nurse #1 was notified of the above documented findings by the surveyor. The Director of Nursing (DON) stated that this resident was able to cut her oxygen up and down in which she has done in the past. The surveyor asked the DON if education had been provided to the resident and was this care planned at any point.<br><br>Registered Nurse #1 provided me a copy of the resident's current care plan. The surveyor asked when was this care plan updated for the education of the resident concerning the resident's O2 settings. Registered Nurse #1 stated "I just updated this just now." This was brought to the surveyor at 5:07 pm on 1/17/18.<br><br>No further information was provided to the surveyor prior to the exit conference on 1/18/18.<br><br>2. The facility staff failed to review and revise the comprehensive person centered care plan for Resident #54.<br>Resident #54 was readmitted to the facility on 6/24/16 with the following diagnoses of but not limited to high blood pressure, diabetes, peripheral vascular disease and chronic | F 657 | | |

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| F 657 | Continued From page 3<br>obstructive pulmonary disease. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) the resident was coded as having a BIMS (Brief interview for Mental Status) score of 00 out of a possible score of 15. Resident #54 was also coded as requiring extensive assistance of 2 staff member for dressing and personal care and is totally dependent on 2 staff members for bathing.<br>The surveyor performed a clinical record review of Resident #54's record on 1/17/18 and 1/18/18. During this clinical record review, the surveyor noted the following physician order dated for 6/26/16 which stated in part " ...Comfort foods only if resident request or ask for food from dietary otherwise do not provide a scheduled tray. May consume comfort foods on his own if chooses. When request comfort foods give nectar thicken liquids ..." The review of the clinical record also documented that the resident had a tube feeding which was connected to start infusing at 6 pm and to end at 6 am.<br>The surveyor also reviewed the current comprehensive person centered care plan, which was dated for 12/21/17, for Resident #54. The surveyor noted the following documentation on the care plan:<br>" Problem: "I have difficulty swallowing so I need a tube feeding."<br>" Approaches: " ...Thicken all my liquids to nectar consistency. Thicken all my liquids to honey consistency. Thicken all my liquids to pudding consistency ..."<br>The administrative team members were notified of the above documented findings on 1/18/18 at approximately 4 pm by the surveyor.<br><br>At 5 pm, Registered Nurse #1 provided an updated copy of the care plan which had the | F 657 | | |

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| F 657 | Continued From page 4<br>following revisions and was dated for 1/18/18:<br>" Approaches: " ...Comforts only if res (resident) req (requests) ask for food from dietary. May consume comfort foods on his own if he chooses. When request give nectar thick liq (liquids)."<br>No further information was provided to the surveyor prior to the exit conference on 1/18/18.<br>3. The facility staff failed to review and revise the care plan to address the diet status and did not have care plans prepared by an interdisciplinary team that consisted of at least the attending physician or non-physician practitioner, registered nurse and nurse aid with responsibility for the resident, and resident and resident representative for Resident # 28.<br><br>Resident #28 is an 88-year-old male who was originally admitted to the facility on 5/5/12 with a readmission date of 8/22/15. Diagnoses included but not limited to: hyperlipidemia, hypertension, major depressive disorder, chronic atrial fibrillation, and hypothyroidism.<br><br>The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/7/17. In Section C of the MDS, Resident #28 was assessed and had a BIMS (brief interview for mental status) score of 12 which indicated moderate impairment.<br><br>The clinical record for Resident # 28 was reviewed on 1/17/18 at 10:02 am. According to the current physician's order that was signed and dated on 12/26/17, Resident #28 had orders for a regular diet with fortified foods.<br><br>The current plan of care for Resident # 28 was reviewed and revised on 12/15/17. When the | F 657 | | |

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| F 657 | Continued From page 5<br>surveyor reviewed the plan of care that addressed the dietary needs of Resident # 28, the plan of care had documented "Problem onset: 12/15/17 I need a therapeutic diet of NAS." (no added salt) The surveyor spoke with the consultant nurse in reference to the current plan of care not being revised to reflect the diet change since the order for a regular diet was implemented on 8/22/15, and the order for fortified foods had been implemented on 12/8/16. The consultant nurse reviewed the care plan with the surveyor and agreed that the care plan should have been reviewed and revised.<br><br>The survey team met with the administrator, consultant nurse, and DON (director of nursing on 1/18/18 at 6:25 pm to discuss the findings.<br><br>No further information regarding why the care plan had not been reviewed or revised to reflect the current diet status of Resident # 28 was provided to the survey team prior to the exit conference on 1/18/17.<br><br>The "Care Plan Meeting Signature Log" for Resident # 28 had documentation of the members present at the time of the care plan. On 4/15/17, the signature log had documentation from LPN MDS staff, social services staff, dietary staff, and activity staff. The surveyor did not locate any documentation in the clinical record that supported that the attending physician or NPP (non-physician practitioner), a registered nurse and nurse aid with responsibility for the resident, the resident, or the resident representative had been involved in the care planning process. On 12/27/17 The signature log for the care plan meeting had documentation from a social worker, 2 other team members that | F 657 | | |

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| F 657 | Continued From page 6<br>did not include titles with their signature, and the resident representative for Resident # 28.<br><br>On 1/18/18 at 9:01 am spoke with MDS coordinator in reference to the "Care Plan Meeting Signature Log." Surveyor asked the MDS coordinator if she could identify who the team members were that did not have titles by their names? The MDS coordinator stated that she did not know who they were and that she had only been there a few weeks. The surveyor asked the MDS coordinator if their care plan team consisted of at least the attending physician, registered nurse or nurse aid with a responsibility to the resident, a member of food and nutrition services, and the resident and their representative. The MDS coordinator stated "not at this time but we are working on it."<br><br>On 01/18/18 9:37 am, the surveyor spoke with DON (director of nursing) in reference to Care Plan team. The DON reviewed the "Care Plan Signature Log" along with the surveyor. The surveyor asked DON if she could show where the facility team is compliant with the having an interdisciplinary team that consisted of at least the resident's attending physician, registered nurse and nurse aid with responsibility for the resident, a member of food and nutrition services, and to the extent possible the resident and resident representative. The DON reviewed the electronic medical records to see if she could find more documentation to support that the involvement of the necessary disciplines in the care planning process. After the DON reviewed the electronic medical record she stated to the surveyor that she could not locate any documentation in the clinical record to support that the necessary disciplines had been involved | F 657 | | |

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| F 657 | Continued From page 7<br>in the care planning process.<br><br>On 1/18/18 at 6:25 pm, the survey team met with the administrator, DON, and consultant nurse to discuss the above findings.<br><br>No further information was provided to the survey team regarding this issue prior to the exit conference on 1/18/18. | f 657 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s) : 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and observation, facility staff failed to follow physician orders for use of oxygen for 1 of 22 residents in the survey sample (Resident# 52)<br><br>The findings included:<br><br>Resident #52 was admitted to the facility *on* 5/29/17 with the following diagnoses of, but not limited to anemia, chronic obstructive pulmonary disease, respiratory failure, anxiety disorder , depression and seizure disorder. On the quarterly MOS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/17/17, the resident was coded as requiring limited | F695 | Resident #52 oxygen concentrator settings was adjusted to 3 liters per minute per order on 1/17/2018 and resident educated only licensed nurse to adjust.<br><br>100% of residents with oxygen orders were observed and all concentrators were on appropriate settings per orders 1/17/2018.<br><br>In-services were provided to RN's LPN's on oxygen administration policy and procedure to include observation of oxygen setting per order 2/1/2018.<br><br>Nursing administration will make rounds on all residents with active oxygen orders to monitor for accuracy of oxygen settings per order no less than three days a week for eight weeks.<br><br>Finding of such audits will be reported by nursing administration to the QA committee who will determine the need or duration of future audits. | 3/3/2018 |

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| F 695 | Continued From page 8<br>assistance of 1 staff member for dressing, personal care and bathing. Resident #52 was also coded as having a BIMS (Brief Interview for Mental Status) of a 15 out of a possible score of 15.<br><br>The surveyor went into the resident's room at 12:21 pm on 1/17/18 and observed the resident's oxygen concentrator was setting on 2 ½ liters/minute by nasal cannula. The surveyor and Corporate Nurse #1 went back into room at 1 pm and the oxygen concentrator was set at 2 1/2 liters/minute. Both reviewed the MD orders and the MD orders stated that the O2 concentrator was to be set at 3 liters/minute.<br><br>01/17/18 04:25 pm the administrative team meeting consisted of the Administrator, Director of Nursing and Corporate Nurse #1 was notified of the above documented findings by the surveyor. The Director of Nursing (DON) stated that this resident was able to cut her oxygen up and down in which she has done in the past. The surveyor asked the DON if education had been provided to the resident and was this care planned at any point.<br><br>Registered Nurse #1 provided me a copy of the resident's current care plan. The surveyor asked when was this care plan updated for the education of the resident concerning the resident's O2 settings. Registered Nurse #1 stated "I just updated this just now." This was brought to the surveyor at 5:07 pm on 1/17/18.<br><br>No further information was provided to the surveyor prior to the exit conference on 1/18/18. | F 695 | | |
| F 757 | Drug Regimen is Free from Unnecessary Drugs | F 757 | | |

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| F 757 SS=D | Continued From page 9<br>CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to ensure that one of 22 Residents (Resident #36) was free of unnecessary drugs.<br><br>The findings included.<br><br>The facility administered the antianxiety medication Xanax and the antidepressant medication Zoloft to Resident #36 without adequate indications for use. These medications were administered to the wrong Resident over a | F 757 | | |

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| F 757 | Continued From page 10<br>three-day period.<br><br>The clinical record review revealed that Resident #36 had been admitted to the facility 08/06/14. Diagnoses included, but were not limited to, atrial fibrillation, constipation, restless leg syndrome, chronic pain, depressive disorder, and dysphagia.<br><br>Section C (cognitive patterns) of the Residents quarterly MOS (minimum data set) assessment with an ARD (assessment reference date) of 12/11/17 included a SIMS (brief interview for mental status) summary score of zero.<br><br>The DON (director of nursing) provided the surveyor with a copy of a "NURSING COMMUNICATION FORM" dated 12/13/17 with the following documentation Per Care Plan: Son requested Resident be put back on Zoloft + wants Xanax back to 0.5 mg BID (twice a day) + wants no further reduction in meds (these meds). This form had been sent to the physician and returned to the facility on 12/15/17 with the following orders "Zoloft 50 mg i (one) po (by mouth) qd (every day) Xanax 0.5 mg po BID..."<br><br>A review of the Residents **eMAR** (electronic medication administration record) revealed that the medication Xanax was started on 12/15/17 at 10:00 p.m. the Resident received six doses. The medication Zoloft was started on 12/16/17 at 10:00 a.m. and the Resident received three doses.<br><br>On 01/17/18, the surveyor spoke with the DON regarding the above medications and a complaint. The DON verbalized to the surveyor that a family member of the Resident had expressed a concern that the Resident was | F 757 | Resident #36 medication error was identified 12/18/2018.<br><br>Order obtained 12/18/2017 to discontinue Zoloft and Xanax.<br><br>Provider assessed resident #36 12/18/2017 and vital signs were monitored for stability x48 hours per order.<br><br>1:1 in-service completed with nurse responsible for medication error 12/19/2017.<br><br>In-services were provided to all RN, LPN's on policies and procedures on accurate completion of communication form to provider including resident name and information/assessment 2/1/2018.<br><br>Nursing administration, provider and medical records will audit a minimum of three resident's orders for accuracy weekly for eight weeks.<br><br>Findings of such audits will be reported by nursing administration to the QA committee who will determine the need or duration of future audits. | 3/3/2018 |

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| CARRINGTON PLACE AT BOTETOURT COMMONS | 290 COMMONS PARKWAY DALEVILLE, VA 24083 |

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| F 757 | Continued From page 11<br>acting differently. Upon reviewing the Residents clinical record, it was discovered that the nurse had written an order for Xanax and Zoloft for the wrong Resident. The DON stated the PA (physician assistant) assessed the Resident and the medications were stopped immediately. The Residents VS (vital signs) were checked every shift X 48 hours with no problems being observed.<br><br>The progress note transcribed by the PA on 12/18/17 read in part "...Chief complaint...Med error...Patient seen for eval of med error family, daughter, present in room she was given zoloft 50 mg and xanax 0.5 mg po bid for 3.5 days that was supposed to be given to another resident patient has been very somnelent and difficult to wake at times her family is very concerned about this error...PHYSICAL EXAM...somnelent resting in bed easily awoken...Normal respiratory effort...confused, no evidence of mood disturbance...Discussed potential side effects and common reactions with these medications in lengthy detail with resident's daughter after thorough examination resident with nurse present in the room she was easily aroused and stated she wanted to go back to sleep. I explained to patients daughter than within the next 24 hours resident should be more alert and the lethargy should wear off there are no expected long term side effects from the medication error this was discussed with the DON and other staff who are taking appropriate measures to report and correct the error."<br><br>The facility provided the surveyor with a copy of a medication error report indicating that the responsible party was notified of the error on 12/18/17 at 1:30 p.m. | F 757 | | |

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| F 757 | Continued From page 12<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference.<br><br>THIS IS A COMPLAINT DEFICIENCY. | F757 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(9) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident staff interview and observation, facility staff failed to securely store | F 761 | Resident #54 nebulizer was placed into medication cart and cart locked at time of surveyor observation by LPN #1 1/17/2018.<br><br>Nursing administration observed all medication carts at time of occurrence 1/17/2018 and no other issues identified.<br><br>In-services were provided to RN's, LPN's on policy and procedure on storage of medications 2/1/2018.<br><br>Nursing administration will observe medication carts to monitor for any noncompliance issues with policy no less than 3 days a week for 8 weeks.<br><br>Findings of such audits will be reported by nursing administration to the QA committee who will determine the need or duration of future audits. | 3/3/2018 |

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| F 761 | Continued From page 13<br>medications on 1 medication cart in the nursing facility for 1 of 22 residents in the survey sample (Resident #54).<br><br>The findings included:<br><br>Resident #54 was readmitted to the facility on 6/24/16 with the following diagnoses of but not limited to high blood pressure, diabetes, peripheral vascular disease and chronic obstructive pulmonary disease. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) the resident was coded as having a BIMS (Brief interview for Mental Status) score of 00 out of a possible score of 15. Resident #54 was also coded as requiring extensive assistance of 2 staff member for dressing and personal care and is totally dependent on 2 staff members for bathing.<br><br>The surveyor observed on 1/17/18 at 2:30 pm in the 500 hallway of the nursing facility, that LPN (Licensed practical nurse) #1 was administering medications to the residents of the 500 hallway. During this observation, LPN #1 was observed to go into a resident's room and leave the following on top of the medication cart, which belonged to Resident #54 in the survey sample: Ipratropium Solution (1) nebulizer treatment. The surveyor interviewed LPN #1 when she returned to the medication cart. The surveyor asked LPN #1 where this nebulizer treatment medication should be stored while she was administrating medications to other residents and she stated "It should have been locked up in the cart."<br>The surveyor notified the administrative team members of the above documented findings on 1/18/18 at approximately 4 pm. The surveyor requested a copy of the facility's medication | F 761 | | |

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| F 761 | Continued From page 14<br>administration policy.<br>The surveyor received a copy of the policy at approximately 4:30 pm. The policy was titled "Administrating Mediations" and under section "Policy Interpretation and Implementation", the policy stated the following:<br>" " ...10. ...No medications are kept on top of the cart ..."<br>No further information was provided to the surveyor prior to the exit conference on 1/18/18. | F 761 | | |
| F 803 SS=D | Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)<br><br>§483.60(c) Menus and nutritional adequacy. Menus must-<br><br>§483.60(c)(1) **Meet** the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed;<br><br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;<br><br>§483.60(c)(5) Be updated periodically;<br><br>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make | F 803 | Resident #72 was interviewed on 1/17/2018 and her food preferences were updated.<br><br>100% of resident's were interviewed and food preferences were updated 1/19/2018.<br><br>Food preferences will be updated annually thereafter.<br><br>All dietary staff in-serviced on reading of tray cards and accuracy of each tray.<br><br>DM and/or RD will observe (3) tray cards for any noncompliance issues no less than 3 days a week for 8 weeks.<br><br>Findings of such audits will be reported by DM to the QA committee who will determine the need or duration of future audits. | 3/3/2018 |

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| F 803 | Continued From page 15<br>personal dietary choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, facility policy review and clinical record review it was determined the facility failed to complete the tray card menu instructions for Resident #72 in the survey sample.<br><br>Findings:<br><br>Resident # 72 was admitted to the facility on 6/27/17. Her diagnoses included diabetes, cancer, anemia, renal failure and depression.<br><br>The latest MDS (minimum data set) assessment dated 1/1/18 coded the resident as cognitively intact. She required the assistance of at least one staff member to accomplish all the ADLs (activities of daily living) and a tray set-up only to eat. The MDS coded the resident with a therapeutic diet.<br><br>The CCP (comprehensive care plan) reviewed and revised on 9/28/17 included the problem of increased risk for altered nutritional status related to her renal failure and metastatic ovarian cancer diagnoses. The interventions included the RD (registered dietician) evaluating the resident's nutritional status. Staff members were to document food intake at each meal.<br><br>Resident # 72's physician's orders, signed and dated on 12/27/17, included and order for Regular/CCD diet (regular texture, diabetic/calorie restricted diet).<br><br>The RD nutritional assessment dated 8/15/17 contained a recommendation for the | F 803 | | |

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| F 803 | Continued From page 16<br>Regular/CCD diet. The RD assessment included parameters for the resident's total calorie, protein, and fluid requirements.<br><br>On 1/17/18 at 10:00 Resident #72 was interviewed in her room. She told the surveyor that she did not like cabbage, broccoli, or zucchini, and had informed the staff of this on many occasions but those items continued to appear on her tray. She said she didn't get a substitute for these items, but the staff would remove the food from her plate because smelling those items made her nauseous. The resident also told the surveyor that the tray card often contained items that were not delivered on her tray. She said she had given up on requesting these from staff, as it just wasn't worth the trouble since they were always so busy.<br><br>On 1/17/18 at 1:00 PM CNA I delivered the lunch tray to Resident #72's room. The surveyor reviewed the tray card and the contents of the tray and observed the 8 oz of milk on the tray card was not delivered with the meal.<br><br>On 1/17/18 at 1:20 PM CNA II picked up the resident tray from her room and placed it in the kitchen cart for return to the kitchen. The surveyor requested to see the remains of the meal and obtained the tray card off the tray. The resident had eaten all the foods and drank her fluids with the exception of the chicken--which CNA II said she complained "was dry and tough". CNA II said she didn't ask the resident if she wanted anything else--because the resident was capable of asking for it herself.<br><br>CNA I joined the interview at that point and both CNAs were asked if they had noticed the milk | F 803 | | |

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| F 803 | Continued From page 17<br>was not on the tray. They both said that was the kitchen's responsibility, but acknowledged neither of them had noticed the item was missing. The CNAs resumed their duties gathering up trays and neither of them reported the missing carton of milk to the kitchen, or returned to the room to ask if the resident wanted the milk.<br><br>The surveyor was seated in the hallway observing the CNAs coming and going in these rooms until 2:20 PM and never saw anyone deliver the milk. At 2:30 PM the resident was questioned about the milk. She said it was not on her tray and no one had provided it or asked if she wanted it.<br><br>These findings were reported to the administrator and DON on 1/17/18 at 4:30 PM.<br><br>On 1/18/18 at 2:30 PM the CDC (corporate dietary consultant) was interviewed about the missing item on the lunch tray and the staff responsibility to provide the foods/drink listed on the card. The CDC said the staff were supposed to follow the directions on the tray card for each meal. The expectation was the staff member delivering the tray would check for accuracy and report any irregularities between the tray card and the actual meal to the kitchen, so it could be corrected.<br><br>The CDC told the surveyor every resident was assessed upon admission by the RD (staff dietitian) and made the recommendations to the physician for meal plans. The physician then ordered on the recommendation of the RD.<br><br>The CDC said the RD reviewed all the menus for the resident and signed off on them. It was then up to the kitchen staff to follow her | F 803 | | |

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| F 803 | Continued From page 18<br>recommendations and the physician's order. She offered a copy of the facility policy on menus for the surveyor to review.<br><br>The policy stated: "....It is the center policy that menus are planned in advance to meet the nutritional needs of the residents/patients in accordance with the Recommended Dietary Allowances of the National Research Council and National Academy of Sciences. Menus will be developed to meet the criteria through the use of an approved menu planning guide.....The Registered Dietician reviews and approves the menus.....will adjust the meal and/or menu plan to meet the individual needs as necessary.....Meals are served as written, unless changed in response to preference, unavailability of an item or a special meal....."<br><br>No additional information was provided prior to the survey team exit. | F 803 | | |
| F 812 SS=F | Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents | F 812 | DM educated on properly temping all foods.<br><br>Hair bonnets are being put into use. All hair will be secure. All dietary staff in-serviced to properly wear hair bonnet.<br><br>All dietary staff in-serviced on proper glove use.<br><br>Can opener was removed and cleaned 1/17/2018.<br><br>Dietary staff in-serviced on cleaning all kitchen equipment. | |

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| F 812 | Continued From page 19<br>from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility document review it was determined the facility kitchen staff failed to follow regulatory requirements to handle, prepare and distribute food.<br><br>Findings:<br><br>The kitchen was toured on 1/17/18 at 11:30 **AM** through 12:40 PM. The OM (dietary manager) accompanied two surveyors on the tour. The following items were observed:<br><br>1. Foods temps on the tray line (all hot foods above 145 degrees) were appropriate--but the **OM** laid the thermometer on table top surface and then picked it up and stuck it in the puree chicken without first cleaning hub with alcohol.<br>2. The OM took the temps on refrigerated peaches for lunch without donning gloves and the hub of thermometer hit the side of cart She did not clean the thermometer prior to sticking it in peaches.<br>3. Staff members did not have hair appropriately restrained with a hairnet. The OM had a hairnet, but hair was sticking out of the sides. KA I (kitchen aide) had on a ball cap and a beard net. Hair was hanging down his neck out from under the ball cap. KA II (kitchen aide) had on a net covering the top of her head but had long locks of hair protruding down her back, beyond her shoulders and unrestrained. KA III was in the food | F 812 | All open food items discarded on 1/17/2018. Dietary staff in- serviced on properly labeling and dating of all food items and all equipment.<br><br>Floors were cleaned on 1/17/2018. Dietary staff in-serviced on proper kitchen sanitation.<br><br>Minute Maid was discarded. All dietary staff in-serviced on storage of personal items.<br><br>Dietary manager or designee will make rounds and document 3 times per week for 8 weeks.<br><br>Findings of such audits will be reported by DM to the QA committee who will determine the need or duration of future audits. | 3/3/2018 |

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| F 812 | Continued From page 20<br>prep area and did not have on a hair net when the surveyors entered the kitchen--but donned one midway through the tour.<br>4. Gloves were not used by all staff members appropriately. Two staff members on the tray line (KA I and KA III) were working without donning gloves. KA I was handling the prepared grilled cheese sandwiches with bare hands. KA III was handling dishware, silverware and napkins with bare hands.<br>5. The table top can opener was observed to have food debris on it and bright silver metal shavings were observed flaked on the backside of the device. The crank was used by surveyor and made an awful grinding noise and spit out more metal shavings. The DM said the opener was cleaned once per month--but probably should be cleaned at least two times a week. The facility administrator was notified 1/17/18 at 2:45 PM of the can opener. He visited the kitchen and returned to tell the surveyor they had washed it off and had cleaned out something stuck in the blades so the device was no longer spitting out metal shavings.<br>6. Bags of corn flakes and toasted oat cereals were observed to be opened and stored on the lower shelves of the kitchen food prep area. Corn flakes were dated 1/7/17, the day the DM said they were received. They staff did not date them when they were opened. The MD said they should be dated when opened and used within seven days of that time.<br>7. The gas stove had six eyes full of food debris and grease. there was also debris on the cook stove top, sides and front, knobs and floor surrounding the area. The DM said she'd only been here two weeks and did not know when the stove was cleaned. She said she would schedule the cleaning. | F 812 | | |

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| F 812 | Continued From page 21<br>8. The oven was observed to have food build-up and grease.<br>9. The floors have food build-up, mop strings and debris throughout kitchen--most prevalent around the legs of prep tables, stoves, tray line tables and lower surface of walls behind sinks, stoves. The DM did not know when the kitchen staff cleaned/mopped those areas.<br>10. An opened package of Argo Starch was observed on the lower shelf of food prep table and was not dated. The MD was not sure when it was opened or how long it should be kept once it was opened.<br>11. In the dry storage room the surveyors observed individual serving bowls containing Rice Krispies to be served the next day to residents. The were dated with a serve by date of 1/20. The DM said they were just prepared and put on cart this AM. 12 bowls on the carts had lids--but four lids were ajar and food left open to air for an unspecified time. (One lid was completely off the bowl).<br>12. The surveyors observed a bottle of Minute Maid fruit punch left in the food prep area by a staff member. It was on lower level of cart containing a bucket of water and cleaning supplies. The MD removed it, stating it belonged to a staff member and they were not supposed to leave their personal food items in the food prep area.<br>13. The kitchen can opener was observed to be mounted on a food prep table top. Surveyor I inspected the device and found food debris on the teeth and surface of the device. The back of the can opener was observed to have a collection of shiny silver shavings clustered on the opener and the tabletop. The can opener made a loud grinding noise like metal on metal when the handle was turned. | F 812 | | |

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

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| F 812 | Continued From page 22<br>The DM pulled the device off the tabletop and wiped the metal shavings off and returned it to the tabletop stand. She told the surveyors it was cleaned about once per month, but noted it probably should be cleaned at least two times a week.<br>On 1/17/18 at 3:30 PM the DCM (dietary corporate consultant) was interviewed about the can opener. She said she had inspected the device and it was clogged with debris. She told the DM to soak it in oil and then clean it. The DCM told the surveyor the obstruction was removed and the can opener was clean and functioning appropriately. She said the kitchen staff were supposed to clean the can opener at the end of each shift and they would educated the staff.<br><br>The facility policy for kitchen staff attire was acquired and contained the following: "..... all staff members have the hair off their shoulders, confined in a hair net or cap, and facial hair properly restrained....."<br><br>The food storage policies were reviewed and contained the following: ".....insures that all food items are stored properly in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.....Wrap all items tightly and label it clearly with a use by date....."<br><br>These findings were reported the facility administrator and the DON on 1/17/18 at 4:30 PM. | F 812 | | |
| F 849 SS=D | Hospice Services<br>CFR(s): 483.70(o)(1)-(4) | F 849 | | |

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| **CARRINGTON PLACE AT BOTETOURT COMMONS** | **290 COMMONS PARKWAY DALEVILLE, VA 24083** |

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| F 849 | Continued From page 23<br>§483.70(0) Hospice services.<br>§483.70(0)(1) A long-term care (LTC) facility may do either of the following:<br>(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.<br>(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.<br><br>§483.70(0)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:<br>(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.<br>(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:<br>(A) The services the hospice will provide.<br>(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.<br>(C) The services the LTC facility will continue to provide based on each resident's plan of care.<br>(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and | F 849 | Resident #50 Hospice care plan was placed on resident medical record 1/18/2018.<br><br>100% of other hospice residents medical records were reviewed on 1/18/2018 with compliance noted.<br><br>In-services were provided to all Hospice services contracted to include Hospice agreement compliance including plan of care on facility medical records 2/1/2018.<br><br>SSD and/or medical records audit a minimum of 2 hospice resident charts for compliance weekly x 8 weeks.<br><br>Findings of such audits will be reported by SSD/MR to the QA committee who will determine the need or duration of future audits. | 3/3/2018 |

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| F 849 | Continued From page 24<br>met 24 hours per day.<br>(E) A provision that the LTC facility immediately notifies the hospice about the following:<br>(1) A significant change in the resident's physical, mental, social, or emotional status.<br>(2) Clinical complications that suggest a need to alter the plan of care.<br>(3) A need to transfer the resident from the facility for any condition.<br>(4) The resident's death.<br>(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.<br>(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.<br>(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.<br>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC | F 849 | | |

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| F 849 | Continued From page 25<br>facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.<br>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.<br>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.<br><br>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.<br>The designated interdisciplinary team member is responsible for the following:<br>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.<br>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality | F 849 | | |

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| F 849 | Continued From page 26<br>of care for the patient and family.<br>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.<br>(iv) Obtaining the following information from the hospice:<br>(A) The most recent hospice plan of care specific to each patient.<br>(B) Hospice election form.<br>(C) Physician certification and recertification of the terminal illness specific to each patient.<br>(D) Names and contact information for hospice personnel involved in hospice care of each patient.<br>(E) Instructions on how to access the hospice's 24-hour on-call system.<br>(F) Hospice medication information specific to each patient.<br>(G) Hospice physician and attending physician (if any) orders specific to each patient.<br>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.<br><br>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.<br>This REQUIREMENT is not met as evidenced by: | F 849 | | |

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| F 849 | Continued From page 27<br>Based on clinical record review, it was determined the facility staff failed to keep a Hospice CCP (care plan) in the clinical record for 1 resident in the survey sample (Resident # 50).<br><br>Findings:<br><br>The facility staff failed to include a Hospice care plan in Resident #50's clinical record. The clinical record was reviewed on 1/18/18 at 3:00 PM.<br><br>Resident #50 was admitted to the facility on 11/7/16. Her diagnoses included hypertension, peripheral artery disease, and dementia.<br><br>The latest MDS (minimum data set) assessment, dated 12/15/17, coded the resident with slight cognitive impairment (BIMS=12). The resident required the assistance of at least 1 staff member for the accomplishment of all the ADL activities with the exception of eating. The resident could feed herself, with tray set-up from the staff. The resident was coded as receiving Hospice care.<br><br>Resident #50's physician's orders, signed and dated 12/27/17, contained an order to admit the resident to hospice services on 12/8/17. The clinical record contained a hospice face sheet, signed and dated by the resident's representative and the hospice representative on 12/8/17. The clinical record did not contain the Hospice facility's plan of care.<br><br>Resident #50 had a facility CCP (comprehensive care plan), dated 12/2/17, that acknowledged the resident was admitted to hospice and briefly outlined the hospice worker's care. Medications and other specifics were not detailed in the facility CCP. | F 849 | | |

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| F 849 | Continued From page 28<br><br>On 1/17/18 at 3:00 PM the ADON (assistant director of nursing) was asked where the hospice care plans were kept. She said they were supposed to be in the clinical record of each resident. The ADON checked the resident's record and said the plan was not there. She said she would call the hospice service and have one faxed over to place in the record. The ADON said it was the Hospice provider's responsibility to place the care plan in the clinical record.<br><br>The contractual agreement between the facility and the hospice provider was obtained and reviewed. The agreement was signed and dated by a representative of the hospice provider and the facility administrator on 12/6/2010.<br><br>The agreement read, in part: "..... Hospice Services are those services provided to a Hospice Patient that are reasonable and necessary for the palliation and management of such hospice patient's terminal illness and are specified in the Hospice Patient's Plan of Care.....nursing care...social services...physician services....counseling services...therapy services...medical supplies.....drugs and biologicals....medical appliances; and medical direction and management of the Hospice Patient.....Facility shall comply with the Hospice Patient's Plan of Care....."<br><br>On 1/18/18 at 6:00 PM these findings were shared with the administrator and the DON. No additional info was provided prior to the survey team exit. | F 849 | | |