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 11/29/2018

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CARRINGTON PLACE OF TAPPAHANNOCK	1150 MARSH STREET TAPPAHANNOCK, VA 22560

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/27/2018 through 11/29/2018. The facility was in substantial compliance with 42 CFR Part 483.73, (emergency preparedness) Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/27/2018 through 11/29/2018. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 20 Resident reviews.	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 set forth in the statement of deficiencies. The Plan of Correction is prepared solely because it is required by the provision of federal and state laws.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental	F 645	1. The PASARR for Resident #8 was located and placed on chart on 11/30/2018. PASARR for Resident #13 and Resident #3 were completed on 12/14/2018 and placed on chart. 2. A 100% audit of residents was conducted and complete by 12/13/2018. Other affected residents will have Level 1 PASARR complete and on chart by 1/11/2019 .	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Administrator — (X6) DATE 12/14/18

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 645	Continued From page 1 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual	F 645	3. In service conducted to Admissions and Social Services on PASARR and required documentation required for placement into SNF facility. Social Services is to audit ten charts every week to ensure compliance with PASARR. Social Services or Admissions will obtain appropriate PASARR on any qualifying residents prior to admission. 4. Findings of weekly audits will be reported to the QA committee, who will determine the need and/or duration of future audits. 5. Compliance date: 1/11/2019.	

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F 645	Continued From page 2 is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, clinical record review, facility record review, and staff interview, the facility staff failed to ensure a Pre-admission Screening and Resident Review (PASARR) was completed prior to admission for 3 residents (Residents #13, #3, and #8) in a sample of 20 residents. 1. For Resident #13, the facility staff failed to ensure a complete Preadmission Screening and Resident Review (PASARR) was conducted prior to admission. 2. Resident #3 did not have a PASARR screening done prior to admission. 3. For Resident #8, the facility staff failed to ensure a PASARR I was completed prior to admission. The Findings included: 1. Resident #13 was admitted on 9-6-18 with	F 645		

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F 645	Continued From page 3 diagnoses including: Psychosis, hallucinations, and dementia. Resident #13's most recent Minimum Data Set (MDS) assessment was an Admission Assessment with an Assessment Reference Date of 9-13-18. The assessment coded Resident #13 as having a Brief Interview of Metal Status Score of 11, indicating mild to moderate impaired cognition. On 11-27-18, an observation of the Resident was conducted during the lunch meal. The Resident was interviewed, and review of Resident #13's record was conducted. Resident #13 was noted to have confused thinking, and difficulty answering questions. The resident was ordered by a physician to receive the following medications: Celexa for depression and anxiety, Cymbalta for mood swings, and Risperdal for psychosis/hallucinations. No previous to admission PASARR was found in the Electronic Health Record (EHR), nor the hard clinical chart. Facility staff were asked to locate Resident #13's PASARR. On 11-28-18, the Director of Nursing (DON) stated that no PASARR had been initiated after the admission of Resident #13, and none could be found in the record prior to admission. On 11-28-18 at the end of day debrief, an interview was conducted with the Director of Nursing (DON), and the Administrator who stated they were just becoming familiar with the PASARR rules, and stated that this error would	F 645		

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F 645	Continued From page 4 be corrected in the future. The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 11-28-18. The Administrator stated, "we will correct this immediately" and indicated they would be auditing residents' PASARRs. No further documents were provided. 2. Resident #3 did not have a PASARR screening done prior to admission. Resident #3 was admitted to the facility on 12/9/15. Diagnoses included dementia, bipolar disorder, high blood pressure and diabetes. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 9/5/18. Resident #3 was coded with a Brief Interview of Mental Status score of 11 indicating moderate cognitive impairment and required extensive assistance with activities of daily living. On 11/27/18 at 3:38 PM, A clinical record review revealed that Resident #3 was on Zyprexa (antipsychotic) and had a diagnosis of bipolar disorder. Further review revealed no PASARR I on the record. On 11/29/18 at 11:42 AM, an interview was conducted with the Social Worker, who stated, "She does not have a PASARR." On 11/29/18 at approximately 12:30 PM, the Administrator and DON (director of nursing) were notified of the above findings.	F 645		

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F 645	Continued From page 5 3. For Resident #8, the facility staff failed to ensure a PASARR I was completed prior to admission. Resident #8, a 68-year female, was admitted to the facility on 03/28/2014. Current diagnoses include anxiety, depression, and bipolar disorder. Resident #8's most recent Minimum Data Set (MDS) with an Assessment Reference date of 09/21/18 was coded as a quarterly review. Resident #8 was coded with a Brief Interview of Mental Status score of "15" out of a possible "15" indicative of no cognitive impairment. The MDS quarterly review also indicated Resident #8 received antidepressant and antianxiety medications. Review of the clinical record revealed there was no PASARR I documentation on the chart. On 11/28/18 at 10:50 AM, the social worker was asked about the PASARR process and she stated she did not know a PASARR I was required for all residents prior to admission. On 11/29/18, the Administrator and DON were notified of findings and offered no further documentation.	F 645		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.	F 773	1. The physician and responsible party of Resident #3 and Resident #4 were notified of lab omissions. 2. A 100% audit of last four months of labs complete on 12/3/2018 with no further omissions noted.	

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F 773	Continued From page 6 (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to notify the physician of laboratory results for two resident (Resident # 3 and #4) in a survey sample of 25 Residents. 1. For Resident #3, the facility staff failed to notify physician of failure to obtain a HGA1C (hemoglobin A1C) as ordered. 2. For Resident #4, the facility staff failed to notify the physician of failure to obtain a Valproic acid level. The findings included: 1. For Resident #3, the facility staff failed to notify physician of failure to obtain a HGA1C (hemoglobin A1C) as ordered. Resident #3 was admitted to the facility on 12/9/15. Diagnoses included dementia, bipolar disorder, high blood pressure and diabetes. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 9/5/18. Resident #3 was coded with a Brief Interview of Mental Status score of 11 indicating moderate cognitive impairment and required extensive assistance with activities of	F 773	3. In service conducted to licensed nurses regarding lab slip verification against physician orders, appropriate specimen collection, and physician notification for any abnormal lab results and omissions. The DON or Unit Manager will audit labs three times weekly to ensure verification of orders and physician notification. 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: 12/12/2018.	

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F 773	Continued From page 7 daily living. On 11/27/18 at 3:38 PM, a clinical record review revealed that Resident #3 was on Zyprexa (antipsychotic) and had a diagnosis of diabetes. A HGA1C was on ordered 9-7-18. No results were found for this lab. On 11/29/18 at 9:30 AM, an interview was conducted with the unit manager, LPN (licensed practical nurse) A. She stated, "It did not get done." 2. For Resident #4, the facility staff failed to notify the physician of failure to obtain a Valproic acid level. Resident #4 was admitted to the facility on 1/23/15. Diagnoses included dementia, congestive heart failure and schizophrenia. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 9/5/18. Resident #4 was coded with a Brief Interview of Mental Status score of 4 indicating severe cognitive impairment and required limited to extensive assistance with activities of daily living. Review of the clinical record revealed a physician's order dated 8-24-18 for labs including a Valproic acid level. Further review showed a lab report dated 8-28-18 which indicated, "Sample tube was rejected for analysis due to specimen submission in a gel barrier tube (incorrect tube)." The physician was not notified of this omission in lab results. On 11/29/18 at 9:30 AM, an interview was	F 773		

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F 773	Continued From page 8 conducted with the unit manager, LPN (licensed practical nurse) A. She stated, "It did not get done." On 11/29/18 at approximately 12:30 PM, the Administrator and DON (director of nursing) were notified of above findings.	F 773		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide an ordered eating assistance, therapeutic device, for one Resident (Resident #13) in a survey sample of 20 Residents. For Resident #13, the facility staff failed to provide a divided plate to assist the Resident with eating at the noon meal on 11-27-18. The findings included: Resident #13 was admitted on 9-6-18 with diagnoses including: Stroke with difficulty eating due to (L) side weakness, hypertension, atrial fibrillation, and diabetes. Resident #13's most recent Minimum Data Set (MDS) assessment was an Admission	F 810	1. After Resident #13 was noted to not receive his adaptive equipment a red divided plate was promptly provided by dietary. Resident consumed 100% of his meal. 2. A 100% audit was complete on all residents with physician orders for adaptive equipment. No further adaptive equipment omissions were noted. 3. All dietary staff in serviced on ensuring adaptive equipment is placed on meal ticket and being utilized for the appropriate residents. The dietary manager and/or designee is to audit adaptive equipment usage three times weekly to ensure appropriate adaptive equipment is being utilized per physician order. 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: 12/13/2018.	

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F 810	Continued From page 9 Assessment with an Assessment Reference Date of 9-13-18. The assessment coded Resident #13 as having a Brief Interview of Metal Status Score of 11, indicating mild to moderate impaired cognition. The Resident was also coded as requiring extensive assistance to total dependence on one to two staff members for all activities of daily living, with the exception of eating which required a special divided plate, and set up help from staff. On 11-27-18, an observation of the Resident was conducted during the lunch meal. The Resident was interviewed, and review of Resident #13's record was conducted. Resident #13 was noted to have confused thinking, and difficulty answering questions. The Resident was eating from a regular dinner plate, and food had been pushed off of the plate onto the table where the Resident could not eat it. The Residents tray card was reviewed and instructed the dining services staff to provide an assistive device for "Divided Plate at all meals" and an "adaptive equipment" list was found in the facility kitchen with the Resident name on it specifying the same thing. The Resident's care plan was reviewed and specified that the divided plate must be used for all meals. The Resident's weight record was reviewed and revealed that the Resident had experienced no weight loss. Immediately after the lunch meal, the Dining Services Director was interviewed and asked why the divided plate had not been used for the	F 810		

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F 810	Continued From page 10 Resident. She stated, "that's my fault, I just missed it". The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 11-28-18. No further information was provided.	F 810		