STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. BUILDING _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	990 HOLSTON RD WYTHEVILLE, VA 24382

(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 complaint survey was conducted 12/10/19 through 12/12/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 107 certified bed facility was 98 at the time of the survey. The survey sample consisted of four (4) resident reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to have a complete and accurate MDS (Minimum Data Set) for 1 of 4 sampled residents (Resident #1) as evidenced by Section K not accurately reflecting the correct weight of Resident #1. The findings included Resident #1 was a resident in the nursing facility. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/1/19 which coded the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #1 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and is totally dependent on 1 staff member for bathing. During the clinical record review and reviewing the weights of Resident #1, the surveyor noted	F 641	F641- Accuracy of Assessments 1.Resident #1 MDS section K0200 was modified and submitted on 12/12/2019. 2.Quality Monitor completed by Director of Nursing/ designee of current resident MDS section K0200 for accuracy of weights. Follow up based on findings. 3.Dietary Manager re-educated by Director of Nursing on accuracy of inputting correct weights in section K0200 on the MDS. 4.MDS/Dietary Manager/designee to conduct random quality monitoring of resident MDS section K0200 to ensure the weight on the MDS is accurately entered 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5.Allegation of Compliance 01/27/2020.	01/27/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: Administrator — (X6) DATE: 1-24-20

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. BUILDING _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	990 HOLSTON RD WYTHEVILLE, VA 24382

(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 641	Continued From page 1 that the weight as documented on the annual MDS with an ARD of 10/1/19 was 200 lbs. The surveyor reviewed the weekly weights of Resident #1 and the resident's weight on 9/5/19 was documented as being as 290 lbs. ON 10/9/19, the resident's weight was documented as being 288.6 lbs. These weights were found in the weight area in the electronic medical record. The surveyor interviewed the dietary manager on 12/11/19 at 3 pm in the conference room. The surveyor notified the dietary manager of the above documented weights for Resident #1 and compared these to the weight that was documented on the MDS as stated above. The dietary manager stated, "I must have put that weight in by mistake. I will go and talk with MDS to get this corrected. The administrator, DON (director of nursing) and the regional director of clinical services was notified of the above documented findings by the surveyor on 12/12/19 at 5:30 pm. No further information was provided to the surveyor prior to the exit conference on 12/12/19.	F 641	F684- Quality of Care 1.Resident #4 discharged from facility on 01/08/2019. 2.Quality Monitor completed by Director of Nursing/designee of current resident allergies to ensure residents do not receive medications that they may be allergic to. Follow up based on findings. 3.Licensed nurses re-educated by Director of Nursing to ensure allergies to medications are checked/verified for each resident prior to administering medications. 4.Director of Nursing/designee to conduct random quality monitoring of resident allergies to ensure residents do not receive medications that they be allergic to 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5.Allegation of Compliance 01/27/2020.	01/27/2020
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. BUILDING _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	990 HOLSTON RD WYTHEVILLE, VA 24382

(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 684	Continued From page 2	F 684		

by:
Based on staff interviews, facility document review and clinical record review, the facility staff failed to ensure that residents receive treatment and care for 1 of 4 sampled residents as evidenced by the facility staff administering a physician ordered antibiotic, Levaquin, even though the resident was allergic to this antibiotic (Resident #4).

The findings included:

The facility staff failed to stop the administration of a physician ordered antibiotic, Levaquin, even though Resident #4 was documented as being allergic to this antibiotic. The facility staff administrated 5 dosages of this antibiotic to Resident #4.

Resident #4 had been a resident in the nursing facility. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/11/18 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 2 out of a possible score of 15. Resident #4 was coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 or 2 staff members for bathing.

The surveyor performed a clinical record review of Resident #4's medical record 12/12/19. On 12/28/18, the physician ordered an antibiotic, Levaquin 500 mg (milligram) 1 po (by mouth) every day for 7 days. On the December, 2018 MAR (Medication Administration Record), the resident was administrated as documented by the facility staff with a check mark for the dates of 12/29/18, 12/31/18, 1/1/19, 1/2/19 and 1/3/19 at 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. BUILDING _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	990 HOLSTON RD WYTHEVILLE, VA 24382

(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 684	Continued From page 3	F 684		

am. On 12/30/18, the facility marked the box with a "N" which represents the medication was not administrated to the resident for this date at 9 am.

The surveyor reviewed the face sheet for Resident #4 on 12/12/19. Under the section of "Allergies" there was documentation that listed "Levaquin" as being an allergy of this resident. The December 2018 and January 2019 MAR was also reviewed. "Levaquin" was noted to be as one of the medications that the resident was allergic to.

A "Nursing Communication Form" dated for 12/31/18 for Resident #4 stated the following: "Pharmacy called and stated resident had previous allergy to levofloxin and resident is currently receiving Levaquin. Please advise." On the bottom of this "Nursing Communication Form" dated for 1/2/19 stated the following: "tolerating, continue med (medicine) remove allergy" with the physician's signature on the bottom of this form. This signature also had a date of 1/2/19.

The administrator, regional director of clinical services and the DON (director of nursing) were notified of the above documented findings on 12/12/19 at approximately 5:30 pm by the surveyor. The surveyor asked the DON what her expectation of the nursing staff was when receiving a physician order for a resident. The DON stated, "I first would look and see if the resident was allergic to this particular medication. If they were, I would expect the nurses to call the physician back and notify him of this information and see what other medication would work instead of the one he/she just ordered." The surveyor asked if the DON could tell if this had been done for this situation. The DON stated, "I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. BUILDING _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	980 HOLSTON RD WYTHEVILLE, VA 24382

(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 684	Continued From page 4 don't see where it was." The surveyor requested and received the facility's policy titled, "Administering Medications" which read in part, " ...9. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications ..." No further information was provided to the surveyor prior to the exit conference on 12/12/19.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(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 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842	F842- Resident Records- Identifiable Information 1.Resident #3 discharged from facility on 08/01/2019. 2.Quality Monitor completed of current residents by Director of Nursing/designee to ensure there is an inventory of personal effects in the medical record. Follow up based on findings. 3.Current Licensed Nurses and Certified Nursing Assistants re-educated by Director of Nursing that the resident's personal belongings and clothing are to be inventoried and documented upon admission and as such items are replenished. 4.Director of Nursing/designee to conduct random quality monitoring of resident inventory sheets to ensure that there is a completed inventory sheet in the medical record 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5.Allegation of Compliance 01/27/2020.	01/27/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. BUILDING _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	990 HOLSTON RD WYTHEVILLE, VA 24382

(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 842	Continued From page 5 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(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 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. BUILDING _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	990 HOLSTON RD WYTHEVILLE, VA 24382

(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 842	Continued From page 6	F 842		

Based on interviews, review of documents, and in the course of a complaint investigation, it was determined the facility staff failed to ensure complete and accurate clinical records for one (1) of four (4) sampled residents (Resident #3).

The findings include:

The facility staff failed to ensure Resident #3's personal property clinical documentation was complete and accurate.

Resident #3's stay at the facility was less than 14 days. Resident #3's "Discharge assessment-return not anticipated" minimum data set (MDS) assessment had the resident assessed as requiring supervision with bed mobility, transfers, eating, and toilet use and as requiring limited assistance with dressing and personal hygiene. Resident #3 was documented as continent of bowel and bladder. Resident #3's diagnoses included, but was not limited to: Alzheimer's disease, dementia, anemia, and high blood pressure.

Resident #3's clinical documentation included a form titled "NEW ADMISSION CHECKLIST". The form had an area to document whether or not certain items of personal property was brought to the facility; the items in this area included, but were not limited to: glasses and dentures (uppers and/or lowers). This form had a signature for the "Resident or Responsible Party" but there was no documentation of if the aforementioned items was or was not brought to the facility.

A blank copy of the "RESIDENT'S VALUABLES LIST" form was provided to the survey team; no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. BUILDING _____ B. WING _____	C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENTER	990 HOLSTON RD WYTHEVILLE, VA 24382

(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 842	Continued From page 7	F 842		

evidence of Resident #3 having this form completed was found by or provided to the survey team. A blank copy of the "DISPOSITION OF RESIDENT'S BELONGINGS AT TIME OF DISCHARGE" from was provided to the survey team; no evidence of Resident #3 having this form completed was found by or provided to the survey team

The following information was found in a facility policy titled "Personal Property" (this policy had no date): "The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished."

A concern related to Resident #3's allegedly missing personal property was discussed with the facility's Director of Nursing (DON) on 12/12/19 at 9:45 a.m. The DON was unaware of the allegation of Resident #3 having personal property missing. The DON acknowledged Resident #3's personal belongings inventory sheet should have been completed at discharge but wasn't.

No documentation of Resident #3's personal belongings being inventoried on admission or at the time of discharge was provided to the survey team prior to exit.

This is a complaint deficiency