STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/29/21 through 7/01/21. The facility was in substantial compliance with 42 CFR Part 483.73, 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 6/29/21 through 7/01/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 120 certified bed facility was 109 at the time of the survey. The survey sample consisted of 25 current Resident reviews and 3 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578	**F-578** **Request/Refuse/Discontinue/Tmt Formulate Adv Directive** **Criteria #1** Resident #79 had DDNR addressed and completed per regulation to include completion of DDNR order form and corresponding documentation within medical record. This was completed prior to survey exit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Ln. NHA — (X6) DATE: 7/25/21

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
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the resident's right to formulate an advanced directive by failing to complete a DDNR (durable do not resuscitate) order form for 1 of 28 residents in the survey sample, Resident #79. The findings included: • For Resident #79, the facility staff failed to complete the resident's DDNR order form.	F 578	**Criteria #2** Residents within the facility had comprehensive DDNR/Advanced Directive audits to identify and address any omissions in the completion of required documentation to ensure compliance with resident wishes as related to Advanced Directives and DDNR status. This was initiated prior to survey exit. **Criteria #3** Facility staff will receive education related to Advanced Directives/DDNR and the completion of required documentation to ensure residents wishes/rights are met. The Social Services Director will complete monthly audits for 3 months on Advanced Directives/DDNRs to identify and address any persisting issues. Corrective measures will be initiated at time of discovery.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 578	Continued From page 2 Resident #79's diagnosis list indicated diagnoses, which included, but not limited to Acute Respiratory Failure with Hypoxia, Vascular Dementia without Behavioral Disturbance, Unspecified Atrial Fibrillation, Chronic Obstructive Pulmonary Disease Unspecified, and Chronic Kidney Disease Stage 3 Unspecified. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 6/07/21 coded the resident as being moderately impaired in cognitive skills for daily decision making with short-time and long-term memory loss. The resident was unable to complete the BIMS (brief interview for mental status) interview. Resident #79's clinical record revealed an active physician's order dated 6/25/21 stating "DNR (do not resuscitate)". The resident's clinical record included a Virginia Department of Health DDNR Order form dated 6/25/21 signed by the FNP (family nurse practitioner). This DDNR states in part: "I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify (must check 1 or 2): 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment (signature of patient	F 578	**Criteria #4** The results of the above-mentioned audits as well as compliance with facility education will be presented to the facility QAPI committee for further recommendation and evaluation of effectiveness of plan of correction. **Criteria #5** The date of compliance with this alleged deficient practice will be July 31, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 578	Continued From page 3	F 578		

is required)
2.The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision."
Neither box in this section had been checked.

Section 2 of the DDNR form states in part:
"If you checked 2 above, check A, B, or C below:
A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.
B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a 'Person Authorized to Consent on the Patient's Behalf' with authority to direct that life-prolonging procedures be withheld or withdrawn. (signature of 'Person Authorized to Consent on the Patient's Behalf is required.)
C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of 'Person Authorized to Consent on the Patient's Behalf is required)."
All three boxes were left blank.

On 7/01/21 at 9:30 am, surveyor spoke with the social worker who stated they usually check the boxes on the DDNR forms but they were on vacation last week and someone else did the DDNR form. Social worker stated they could check the boxes now if the surveyor would like them to. Surveyor stated for the social worker to follow their usual facility procedure. Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 578	Continued From page 4 later spoke with the social worker and UM (unit manager) #1 and UM #1 stated they completed the DDNR form last week and did not check the boxes at that time. Social worker provided surveyor with an updated copy of Resident #79's DDNR order form with box #2 checked in section 1 of the form and C checked in the second section. The checked boxes were initialed by UM #1. Social worker stated the updated order form will be placed in the clinical record. The concern of Resident #79's incomplete DDNR was discussed with the administrator and director of nursing during a meeting on 7/01/21 at approximately 6:30 pm. No further information was provided to the survey team prior to the exit conference on 7/01/21.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580	**F-580 Notification of Changes** **Criteria #1** A meeting and IDT care discussion was held with Resident #57's provider to verify orders as well as any need for precautions was conducted prior to survey exit and corrections/clarifications were made at the time of meeting/discussion. **Criteria #2** Audits will be conducted of facility residents' medical records related to order changes notifications as well as isolation precautions for residents with diagnosis consistent with requiring contact precautions within the facility. Corrections and clarifications if needed will be made at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 5 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review the facility staff failed to notify the facility physician of a change in condition for 1 of 28 residents, Resident #57. The findings included:	F 580	**Criteria #3** Comprehensive Staff education will be completed with facility staff to include facility policy and procedure related to the notification requirements with changes in care/orders as well as processing and initiating contact precautions. The DON will assign and monitor the completion of monthly audits related to notification of providers related to changes in orders/care and the appropriate initiation of contact precautions. Audits will be conducted for three months. **Criteria #4** The results of the above-mentioned audits as well as compliance with education will be presented to the facility QAPI committee for further evaluation and recommendation as well as any alterations in process deemed necessary. **Criteria#5** The date of compliance with this alleged deficient practice will be July 31, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 580	Continued From page 6 For Resident #57 the facility staff failed to verify a medication change and failed to verify contact precaution orders with the resident's physician. Resident #57's face sheet listed diagnoses which included but not limited to pyelonephritis, ESBL (extended spectrum beta lactamase) resistance, urinary tract infection, hypertension, atrial fibrillation, type II diabetes mellitus, depression, sepsis, MRSA (methicillin resistant staphylococcus aureus) and chronic kidney disease. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/20/21 assigned the resident a BIMS (brief interview for mental status) 12 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Resident #57's comprehensive care plan was reviewed and contained a care plan for "Risk for infection R/T (related to) multiple chronic disease processes and communal living environment". Resident #57's clinical record was reviewed and contained a signed physician's order summary for 06/15/21-06/30/21, which read in part "General 06/12/2021-Open-Ended ON ISOLATION FOR MRSA IN PICC (peripherally inserted central catheter) LINE" and "Prescription 06/12/2021-06/27/2021 BACTRIM caplet; 800 mg; amt: 1; oral Special Instructions: BACTRIM 800 mg PO x 14 DAYS FOR MRSA Twice A Day; 09:00 AM, 09:00 PM" Surveyor observed Resident #57 on 06/29/21 at approximately 4:20 pm. Resident in private room. No contact precaution signage noted on	F 580		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 7 resident's door and no isolation cart observed. Surveyor spoke with CNA (certified nurse's aide) #1 on 06/29/21 at approximately 4:25 pm and asked CNA #1 if Resident #57 was on contact precautions and CNA #1 stated that they were not. Surveyor spoke with LPN (licensed practical nurse) #1 on 06/29/21 at approximately 4:35 pm. Surveyor asked LPN #1 if Resident #57 is on precautions and LPN #1 stated they are not. LPN #1 stated resident came back from hospital on 06/11/21. On 06/12/21, the hospital called and said they had pulled the resident's PICC line and it grew MRSA. LPN #1 stated they put her on contact precautions, but on Monday (06/14), the unit manager, told them the resident did not need to be on precautions, so "I took it down". Surveyor asked LPN #1 if they had called the Dr to confirm the orders, and LPN #1 stated they had not. Surveyor asked LPN #1 if they should have and LPN #1 stated that they should. Surveyor LPN #1 if they had discontinued the contact precaution order and LPN #1 stated they had not. Surveyor spoke with ICP (infection control preventionist) on 06/29/21 at approximately 4:45 pm. Surveyor asked ICP if the resident should have been on contact precautions and if the physician notified and ICP stated that the resident should have been on precautions and the physician should have been notified. Surveyor spoke with facility FNP (family nurse practitioner) on 06/30/21 at approximately 8:50 am. Surveyor asked FNP if they had been notified of Resident #57's PICC line testing positive for MRSA. FNP stated to surveyor, "... (Resident #57) went out due to mental health issues. We	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 580	Continued From page 8	F 580		

had tried to remove her PICC here, but she wouldn't let us. She calmed down at the hospital and they pulled the PICC. I don't recall if they called. They should have called prior to placing her on contact precautions and prior to discontinuing precautions. Dr. ... (name omitted) did her readmit on 06/14/21". Surveyor asked FNP if resident should have been on contact precautions, and FNP stated that resident did not need to be on contact precautions.

Surveyor spoke with Dr. ... (name omitted), the facility medical director, on 06/30/21 at approximately 1:20 pm. Surveyor asked the medical director if they had been notified of resident's PICC line having grown MRSA, and medical director stated they had no information on this. Medical director stated that facility staff should have called for directions and stop date for contact precautions. Medical director stated that resident should have remained on contact precautions for the duration of treatment "even though the risk of spread is low". Medical director also stated, "There was no mention to me that she had grown MRSA. Been nice to have blood cultures." Surveyor asked medical director if the facility staff had confirmed the Bactrim order with them, and physician stated they had not.

Surveyor spoke with unit manager on 06/30/21 at 2:30 pm. Surveyor asked unit manager why they had told LPN #1 to discontinue Resident #57's contact precautions, and unit manager stated they had talked with the facility FNP, and they had said it wasn't necessary for resident to be on contact precautions.

Resident #57's clinical record contained a physician's progress noted, dated 06/14/21 which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 580	Continued From page 9	F 580		

read in part "Resident on rounds for readmission following a hospitalization with ... (name omitted) for severe agitation and mood instability, yelling and paranoid and agitated. She was dx (diagnosed) with 'UTI' (urinary tract infection) but her UC (urine culture) was neg. She was dc (discharged) on cefinir (sic) then to start keflex daily as ppx (prophylactic) dosing for 90 d (days) and a referral to urology. Hospital records are limited but reviewed...."

Surveyor reviewed hospital discharge form, which indicated that resident was discharged back to facility with new medication orders of "cefdinir (Omnicef) Take 1 capsule (300mg total) by mouth 2 (two) times a day for 10 days-start date 06/11/21 end date 06/21/21" and "cephalexin (Keflex) capsule Take 1 capsule (250 mg total) by mouth daily for 90 days-start date 06/21/21 end date 09/19/21".

Surveyor reviewed the facility policy entitled "Resident Rights-Notify of Changes", which read in part "Procedure: 1. A facility will immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is: c. A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or... 2. When making notification the facility will ensure that all pertinent information is available and provided upon request to the physician." and "Subject: Change in Condition Process. Situations requiring notification include: 3. A need to alter treatment significantly; that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 580	Continued From page 10 form of treatment. This may include: a. A new infection or wound." Surveyor also reviewed the facility policy entitled "Verbal Orders", which read in part "Policy Interpretation and Implementation 1. Only authorized, licensed practitioners, or individual authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record". Surveyor spoke with the DON (director of nursing) on 07/01/21 at approximately 5:45 pm. Surveyor asked the DON if a physician from the hospital can give a verbal order for a resident after they have been discharged from the hospital and readmitted to the facility. DON stated that hospital physicians are not practicing physicians of the facility, and as such, any orders would need to be confirmed by the facility physician prior to implementation. The concern of the facility failing to notify the resident's physician of a medication change and verify the need for contact isolation was discussed with the administrative staff (administrator, DON) on 07/01/21 at approximately 6:35 pm. No further information was provided prior to exit.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583	**F-583 Privacy and Confidentiality** **Criteria #1** The visible resident information observed during survey rounds was covered and corrected at time of discovery.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 583	Continued From page 11 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to provide for confidentiality of personal and medical records by not securing resident identifiable information on one of six resident care halls. On 07/01/21 at 2:10 PM, the surveyor walked up to the medication cart on the 400 hall. The laptop was open to a resident's file, a clipboard with the	F 583	**Criteria #2** Rounds were immediately conducted, and education completed with staff related to the protection of identifiable health information to include closing computer screens and placing documents with identifying information face down while providing care. **Criteria #3** Education with facility staff will be completed related to the protection of identifiable health information. Education will include computer screen protection as well as reporting sheets with resident identifiers. Environmental facility rounding will be conducted 3 times weekly on various shifts/times for one month by the administrator and DON to identify any visible resident health information in the care area. Corrections will be made at the time of discovery and supplemental individual education provided. **Criteria #4** Results of the audits and education will be presented to the facility QAPI committee for further evaluation, recommendation or resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

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CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 583	Continued From page 12 resident names and room numbers and notes was face up on the medication cart, and reorder stickers were on the border of the display. The nurse came out of a resident room and stated she had been trying to draw some blood before 2 PM. When asked about resident information being visible, the nurse apologized and covered the information. The surveyor notified the administrator and director of nursing of the concern during a summary meeting on 7/1/2021.	F 583		
F 684 SS=E	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 by: Based on staff interview, clinical record review, facility document review, and during a medication pass and pour observation, the facility staff failed to ensure the residents receive treatment and care in accordance with the comprehensive person-centered care plan for 5 of 28 residents in the survey sample, Residents #58, #49, #57, #61, and #9. The findings included: 1. For Resident #58, the facility staff failed to	F 684	**F 684 Quality of Care** **Criteria #1** 1.The resident (#58), MD, and RP was notified of the omission of the prescribed medication and no change in treatment was initiated. Nursing staff was educated related to appropriate response to medications unavailable at time or prescribed administration. Staff education was initiated related to the contents of Cubex and process of obtaining medications through	

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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F 684	Continued From page 13 follow the physician's order for the administration of the oral antibiotic, Vacomycin to treat c. diff (clostridioides difficile). Resident #58's diagnosis list indicated diagnoses, which included, but not limited to End Stage Renal Disease, Chronic Diastolic Congestive Heart Failure, Type 2 Diabetes Mellitus without Complications, and Bipolar Disorder Unspecified. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 5/26/21 assigned the resident a BIMS (brief interview for mental status) score of 13 out of 15 in section C, Cognitive Patterns. A nursing progress note dated 5/31/21 6:04 pm states in part, "positive for CDIFF, (name omitted) NP (nurse practitioner) notified, awaiting new orders". Resident #58's physician's orders included an order dated 6/0/21 for Vancomycin 125 mg oral every 6 hours at 12:00 am, 6:00 am, 12:00 pm, and 6:00 pm. A review of the June 2021 MAR (medication administration record) revealed that the Vancomycin was not administered on the following dates with the reasons documented as: 6/01/21 12:00 pm - "On Hold" 6/01/21 6:00 pm - "On Hold" 6/06/21 6:00 pm - "Drug/Item Unavailable" 6/07/21 12:00 am - "On Hold" 6/07/21 6:00 pm - "Drug/Item Unavailable" and "called pharmacy" 6/08/21 12:00 am - "On Hold" 6/08/21 6:00 am - "On Hold" 6/08/21 12:00 pm - "On Hold" and "on hold md aware pharmacy notified to be on next run" 6/08/21 6:00 pm - "On Hold" and "on hold, MD	F 684	the device. Immediate Corrective measures were initiated prior to survey exit. 2. Resident#49 received a skin assessment prior to survey exit, the MD and RP was notified of the missing assessments. Education was initiated related to the completion of skin assessments per orders as well as facility protocols related to skin assessments. 3. The resident (#57), MD, and RP was notified of the omission of the prescribed medication and no change in treatment was initiated. Nursing staff was educated related to appropriate response to medications unavailable at time or prescribed administration. Staff education was initiated related to the contents of Cubex and process of obtaining medications through the device. Immediate Corrective measures were initiated prior to survey exit. 4. Resident #61 received a skin assessment prior to survey exit, the MD and RP was notified of the missing assessments. Education was initiated related to the completion of skin assessments per orders as well as facility protocols related to skin assessments.	

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 684	Continued From page 14 aware pharmacy notified to get on next run" 6/09/21 12:00 am - "Drug/Item Unavailable" 6/09/21 6:00 am - "Drug/Item Unavailable" 6/09/21 12:00 pm - "Drug/Item Unavailable" and "on hold MD notified and pharmacy notified" The above order was discontinued on 6/09/21 and a subsequent order dated 6/09/21 stated Vancomycin 125 mg oral every 6 hours at 12:00 am, 6:00 am, 12:00 pm, and 6:00 pm. A review of the June 2021 MAR revealed that the Vancomycin was again not administered on the following dates with the reasons documented as: 6/09/21 6:00 pm - "Drug/Item Unavailable" and "on hold MD aware pharmacy notified" 6/10/21 12:00 am - "On Hold" and "MD aware" 6/10/21 6:00 am - "Drug/Item Unavailable" and "still awaiting from pharmacy" On 7/01/21 at approximately 4:40 pm, surveyor notified the DON (director of nursing) of the above, DON stated they would look into this. Surveyor requested and received the list of medications available in the facility Cubex onsite medication supply which listed Vancomycin 125 mg capsules with the on hand quantity listed as "10". On 7/01/21 at 5:20 pm, the DON stated that other than the nurses' lack of knowledge of the medication being in the Cubex, there is no reason for it not to have been given. On 7/01/21 at approximately 6:30 pm, surveyor discussed the concern of Resident #58 not receiving Vancomycin as ordered by the physician with the administrator and DON.	F 684	5. Resident #9, RP, and Provider was notified of incorrect administration dosage. Immediate education was conducted with nursing staff related to medication dose verification. **Criteria #2** Residents with orders for weekly skin assessment will be reviewed for completion of assessment per order. Corrective measures will be initiated as deemed necessary based upon review findings. Medication Administration Records will be reviewed for existing residents to identify any omissions, unavailable, or held meds without appropriate follow up and/or action steps documented for resolution. Corrective Measures will be initiated as deemed necessary based upon review findings **Criteria #3** Comprehensive Education will be completed with nursing staff to include following provider orders, obtaining medications from pharmacy, access to cubex and cubex contents, and dosage verification prior to administration as well as the completion of skin assessments. Components of required documentation of all above	

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 684	Continued From page 15 No further information regarding this issue was presented to the survey team prior to the exit conference on 7/01/21. 2. For Resident #49, the facility staff failed to follow the physician's order for weekly skin assessments. Resident #49's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus without Complications, Cerebral Palsy Unspecified, Unspecified Dementia without Behavioral Disturbance, Schizophrenia Unspecified, and Barrett's Esophagus without Dysplasia. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/13/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15, indicating severe impairment, in section C, Cognitive Patterns. Resident #49 was coded as requiring extensive assistance in bed mobility and being totally dependent on staff for toilet use, personal hygiene, and bathing. In section M, Skin Conditions, the resident was coded as being at risk of developing pressure ulcers/injuries. Resident #49's current physician's orders included an active order dated 4/26/21 stating, "Skin check weekly on Friday 7PM-7AM", however, the most recent weekly skin assessment in the resident's clinical record was dated 3/29/21. The physician's order for skin checks weekly on Friday 7pm-7am was initialed on the June 2021 MAR (medication administration record) on 6/04/21, 6/11/21, 6/18/21, and 6/25/21.	F 684	mentioned education topics will be included in each section. MAR audits will be conducted 5 times per week for 4 weeks by DON or designee as part of the daily clinical meeting to review any omissions, holds, or unavailable medications. Medication cards of residents that have meds ordered that require multiple tabs to achieve ordered doses will be reviewed with MAR to ensure appropriate doses are being administered weekly for 4 weeks by DON or designee. Notices for dose verification will be noted on medication carts as reminder. Corrective measures will be taken upon discovery. Results of the audits will be forwarded to the facility QAPI committee. Skin assessments will be reviewed weekly for 4 weeks to ensure compliance with provider order or facility protocol. Corrective measures will be completed at time of discovery. **Criteria #4** The facility QAPI committee will review the results of the above-mentioned audits and reviews to determine resolution, further recommendations, or additional interventions as deemed necessary.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

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F 684	Continued From page 16 The most recent "Braden Scale for Predicting Pressure Sore Risk" dated 5/13/21 assigned Resident #49 a score of "14 points moderate risk" for skin breakdown. Surveyor requested and received the facility policy entitled, "Pressure Ulcer Risk Assessment" which states in part, "Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated". On 6/30/21 at approximately 3:35 pm, surveyor notified the administrator and DON (director of nursing) of Resident #49's lack of documentation of weekly skin assessments in the clinical record. On 7/01/21 at approximately 10:40 am, surveyor spoke with the DON who stated they were also unable to locate skin assessments for Resident #49. No further information regarding this issue was presented to the survey team prior to the exit conference on 7/01/21. 3. For Resident #57 the facility staff failed to administer the medication clonazepam per the physician's order Resident #57's face sheet listed diagnoses which included but not limited to pyelonephritis, ESBL (extended spectrum beta lactamase) resistance, urinary tract infection, hypertension, atrial fibrillation, type II diabetes mellitus, depression, sepsis, MRSA (methicillin resistant staphylococcus aureus), delirium, and chronic kidney disease. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of	F 684	**Criteria #5** The date of compliance of this alleged deficient practice will be July 31, 2021.	

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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F 684	Continued From page 17 05/20/21 assigned the resident a BIMS (brief interview for mental status) 12 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Resident #57's comprehensive care plan was reviewed and contained a care plan for "Resident has DX (diagnosis) of Depression without psychosis, Anxiety with panic attacks and a history of suicidal ideation. 3/15/21-New orders for antianxiety medication-DX anxiety. 3/25/21-New orders noted to refer to neurology". Resident #57's clinical record was reviewed and contained a physician's order summary, which read in part "clonazepam-Schedule IV tablet; 0.5 mg; amt (amount): 2 tablets; oral Special instructions: Give 2 tablets (1 mg) TID (three times a day) for anxiety Three Times A Day; 09:00 AM, 02:00 PM, 09:00 PM" , "clonazepam-Schedule IV tablet; 0.5 mg ; amt: 1 tab; oral Once An Evening; 10:00 PM", and "May give medications when available from Pharmacy within 24 hours". Resident #57's eMARs (electronic medication administration record) for the month of May 2021 were reviewed and contained an entry which read in part "clonazepam-Schedule IV tablet; 0.5 mg; Amount to Administer: 2 tablets; oral". This entry was initialed as not administered on 05/21/21 at 9:00 pm, 05/22/21, and as only tablet given on 05/29/21 at 9:00 pm. The "Reasons/Comments" section of the eMAR contained notes which read in part, "05/21/2021 9:00 PM Not Administered: On Hold Comment: notified MD", "05/22/2021 9:00 AM Not Administered : On Hold", "05/22/2021 2:00 PM Not Administered: On Hold Comment: Per MD order", "05/22/2021 9:00 PM	F 684		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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F 684	Continued From page 18	F 684		

Not Administered: On Hold Comment: md aware", and 05/28/2021 9:00 PM Not Administered: Other Comment: only one for 1 tab po tid, not 2 tabs"

Resident #57's eMAR for the month of May 2021 also contained an entry which read in part, "clonazepam-Schedule IV tablet; 0.5 mg; Amount to administer: 1 tab; oral." This entry was initialed as not administered on 05/22/21, 05/23/21, 05/29/21, 05/30/21 and 05/31/21. The "Reasons/Comments" section of the eMAR contained notes, which read in part "05/22/2012 10:00 PM Not Administered: On Hold Comment: md aware", "05/23/2021 10:00 PM Not Administered: On Hold", 05/29/2021 10:00 PM Not Administered: On Hold", 05/30/2021 10:00 PM Not Administered : On Hold", and "0531/201 10:00 PM Not Administered: On Hold".

Surveyor requested and was provided with a list of medications contained within the facility stat supply (Cubex). This list contained the medication "clonazepam 0.5 mg- 5 units".

Surveyor spoke with the DON (director of nursing) on 07/01/21 at approximately 5:20 pm regarding the resident's medication not being administered. DON stated, "Other than the nurse's lack of knowledge of it (medication) being in Cubex, there is no reason for it not to have been given".

The concern of not administering the resident's medications as ordered by the physician was discussed with the administrative staff during a meeting on 07/01/21 at approximately 6:35 pm.

No further information was provided prior to exit.

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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F 684	Continued From page 19 4. The facility staff failed to complete a weekly skin assessment as ordered for Resident #61. Resident #61's face sheet listed the resident's diagnoses to include but not limited to, end stage renal disease, peripheral vascular disease, type 2 diabetes mellitus, schizophrenia, and dependence on renal dialysis. The minimum data set (MDS) with an assessment reference date (ARD) of 5/11/2021 noted in Section C (Cognitive Patterns) the resident's brief interview for mental status (BIMS) score was 15 out of 15. A review of Resident #61's physician orders revealed an order for "skin assessment every week on Saturdays night shift 7p-7a with complete set of vital signs" with a start date of 6/19/2021 and an open ended stop date. The resident's clinical record contained evidence of a skin assessment documented on Saturday, 6/20/2021 however no other skin assessments were found, specifically for night shift on 6/26/2021. The DON (director of nursing) was asked about this order and any supporting documentation that the order had been carried out. On 7/01/2021 at approximately 5:30 p.m. the DON stated they were unable to find a skin assessment since the start of that order other than the 6/20/2021 skin assessment. Resident #61's vital signs were documented for 6/26/2021 at 4:06 a.m. (temperature 98.2, pulse 68, respirations 18, blood pressure 132/68, and oxygen saturation 96%). The DON provided a policy titled, "Admission Assessment and Follow Up: Role of the Nurse" which read in part under assessment, "2. Skin Assessment. Skin will be assessed for the presence of developing pressure ulcers on a	F 684		

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F 684	Continued From page 20 weekly basis or more frequently if indicated." The administrator and DON were informed of these findings during a meeting on 7/01/2021 at 6:37 p.m. No further information was provided prior to exit. 5. For Resident #9, the facility staff failed to follow physician orders. The physician ordered carvedilol 3.125 mg two tablet's by mouth every morning to equal 6.25 mg. The nursing staff only administered one tablet. Resident #9's face sheet in the (EHR) electronic health record included the diagnoses, diabetes, acute diastolic heart failure, and chronic kidney disease. Section C (cognitive patterns) of Resident #9's annual (MDS) minimum data set assessment with an (ARD) assessment reference date of 04/01/21 included a (BIMS) brief interview for mental status summary score of 13 out of a possible 15 points. 06/30/21 8:22 a.m., the surveyor observed (LPN) licensed practical nurse #2 prepare and administer Resident #9's morning medications. LPN #2 administered resident #9 one 3.125 mg of carvedilol. 06/30/2021, Resident #9's current physician orders included an order for carvedilol tablet 3.125 mg two tablets by mouth every morning for a total of 6.25 mg. 06/30/21 9:17 a.m., LPN #2 verified Resident #9's medication orders and stated they had only given one carvedilol and the physicians order read two. LPN #2 then prepared and administered Resident #9's second tablet of carvedilol.	F 684		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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F 684	Continued From page 21 06/30/21 3:34 p.m., the administrator and (DON) director of nursing were made aware of the issue regarding Resident #9's carvedilol. No further information regarding this issue was provided to the surveyor prior to the exit conference.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: 2. For Resident #79, the facility staff failed to initiate treatment to a DTI (deep tissue injury) to the right heel on admission on 6/01/21. Resident #79's diagnosis list indicated diagnoses, which included, but not limited to Acute Respiratory Failure with Hypoxia, Vascular Dementia without Behavioral Disturbance, Unspecified Atrial Fibrillation, Chronic Obstructive Pulmonary Disease Unspecified, and Chronic Kidney Disease Stage 3 Unspecified.	F 686	**F 686 Treatment/Services to Prevent/Heal Pressure Ulcer** **Criteria #1** The Provider and Skin Nurse, with Director of Nursing reviewed and assessed resident #79 cited DTI, and comprehensive plan of care with subsequent orders were received. The Provider and Wound Nurse conducted a comprehensive assessment of resident #32. A comprehensive treatment plan and assessment protocol was identified and initiated. **Criteria #2** Residents in facility will have comprehensive skin assessments completed and areas identified will be reviewed by the provider and IDT to develop treatment plan and individual assessment protocols based upon needs and any identified alteration in skin integrity.	

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 686	Continued From page 22 The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 6/07/21 coded the resident as being moderately impaired in cognitive skills for daily decision making with short-time and long-term memory loss in section C, Cognitive Patterns. The resident was unable to complete the BIMS (brief interview for mental status) interview. In section M, Skin Conditions, the resident was code for the presence of one unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar present on admission and one unstageable pressure injury presenting as deep tissue injury also present on admission. A review of Resident #79's clinical record revealed the following documentation: An admission nursing progress note dated 6/01/21 2:43 pm states in part, "Skin assessed and area noted to sacrum, open with yellow exudate, cleaned and comfort foam patch applied. Right heel has DTI noted. Heel protectors on bilateral feet". The "Admission Observation" dated 6/01/21 7:51:56 pm states in part, "Open area to sacrum, dressing applied. Open area to right heel, heel protectors worn". Surveyor reviewed Resident #79's physician's orders and June 2021 TAR (treatment administration record) and was unable to locate a treatment order for the area to the resident's right heel or documentation of treatments administered to the area until 6/25/21. A "Focused Observation" for skin dated 6/25/21 4:22:19 am, states in part, "Deep tissue on sacrum and right heel. Dressing applied and	F 686	**Criteria #3** Education will be completed with clinical staff related to the care and treatment of alterations in skin integrity, skin assessment protocols, admission skin assessments and initiating treatment, as well as documentation requirements. The DON or designee will conduct weekly audits of completion of skin assessments and treatment orders to ensure compliance with protocol and provider orders. Reviews of treatment as well as observations will be conducted by the DON and Wound nurse weekly for four weeks to further evaluate compliance with treatment and assessment protocols and needs for additional interventions. **Criteria #4** The Director of Nursing and Wound care Nurse will present the results of the above-mentioned audits as well as education to the facility QAPI committee for further discussion, recommendation, and intervention/resolution. **Criteria #5** The date of compliance for this alleged deficient practice will be July 31, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

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CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 686	Continued From page 23 resident repositioned for pressure relief". A current physician's order dated 6/25/21 states, "cleanse right heel with wound cleanser, pat dry, apply betadine to wound, cover with kerlix daily and as needed for soilage". On 6/30/21 at approximately 11:05 am, surveyor spoke with the Wound Nurse who stated they did treatments using betadine to the resident's right heel since admission but did not have an order. Surveyor requested and received the facility policy entitled, "Pressure Ulcer Treatment" which states in part: The following information should be recorded in the resident's medical record, treatment sheet or designated wound form: 1. The date and time the dressing was changed. 3. The name and title of the individual changing the dressing, or initials. 4. The type of dressing used and wound care given. On 7/01/21 at approximately 6:30 pm, surveyor met with the administrator and director of nursing and discussed the concern of Resident #79 being admitted on 6/01/21 with a DTI to the right heel and a treatment order for the area was not obtained until 6/25/21. No further information was provided to the survey team prior to the exit conference on 7/01/21. Based on observations, interviews, and the review of documents, it was determined the facility staff failed to provide services necessary to prevent and/or treat pressure wounds/ulcers for two (2) of 28 sampled residents (Resident #32 and Resident #79).	F 686		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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F 686	Continued From page 24 The findings include: 1. The facility staff failed to consistently and completely assess Resident #32's skin. The facility staff failed to promptly provide Resident #32 treatment when skin issues were identified. Resident #32's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/7/21 was signed as completed on 5/14/21. Resident #32 was assessed as usually being able to make self understood and as usually being able to understand others. Resident #32's Brief Interview for Mental Status (BIMS) summary score was documented as a three (3) out of 15. Resident #32 was assessed as requiring assistance with bed mobility, transfers, dressing, and personal hygiene. Resident #32's diagnoses included, but were not limited to: anemia, high blood pressure, dementia, and history of traumatic brain injury. Resident #32's oral intake had been documented as decreased but the facility dietitian, speech therapist, and nurse practitioner had evaluated the resident. Resident #32 had an order for comfort care; which included for no weights to be obtained. The comfort care order had been renewed on 2/12/21. Prior to being admitted to the facility Resident #32 had been receiving hospice care (but had been discharged from hospice care). Resident #32 was care planned for being at risk for pressure ulcers. This care plan was started on 10/27/21 with an approach of weekly skin assessments. Resident #32 had a medical provider order, dated 2/18/21, for weekly skin checks.	F 686		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 25 A facility policy and procedure titled "Pressure Ulcer Risk Assessment" (with a revised date of February 2014) included the following information: - "Skin Assessment. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated." - "The following information should be recorded in the resident's medical record utilizing facility forms: ... The condition of the resident's skin (i.e., the size and location of any red or tender areas) ... Documentation in medical record addressing MD notification if new skin alteration noted with change of plan of care if indicated ..." Resident #32's clinical record included a weekly skin assessment documented on 6/7/21; this assessment referenced a known skin area to the resident's chin that had been receiving treatment. The next weekly skin assessment was documented on 6/28/21 by a licensed practical nurse (LPN); this assessment identified the resident was receiving treatment to their chin, buttocks, and heels. The aforementioned 6/28/21 skin assessment did not provide measurements or a description of the buttocks and heels wounds. LPN #23, a unit manager, was asked about the gap in Resident #32's weekly skin assessments; LPN #23 confirmed there had been a two (2) week gap in Resident #32's weekly skin assessments. Resident #32's clinical record included documented on a form titled "Point of Care History" which indicated on 6/21/21 at 11:15 p.m. a red area was noted to Resident #32's buttocks; no additional assessment of this area was documented at the time the area was discovered.	F 686		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 26 An entry was found on a 6/24/21 medical provider notification document that indicated the resident was found to have a "bed sore to sacrum". The facility's wound care nurse confirmed they had not completed an assessment form for the sacral wound which would have included a description and measurements of the wound. Orders for Resident #32's sacral wound care was documented as being given on 6/25/21. Resident #32 was observed to receive wound care on the morning of 7/1/21. The facility's wound care nurse provided treatment to a chin wound, bilateral heel areas, a dark area to the bottom of the right foot, and bilateral ankle wounds. (The bilateral ankle wounds were reported as just discovered at the time of the 7/1/21 wound care.) The facility staff removed a dressing from the bottom of the right foot that was dated 6/30/21; no order was found for this dressing until 7/1/21. Resident #32's clinical record included documentation of the size and description of the chin wound; no documentation of the size and description of the sacrum, heel, and foot wounds/areas were found. On 7/1/21 at 5:21 p.m., the facility's Director of Nursing (DON) was asked about the measurements and description of Resident #32's wounds. The DON reported only Resident #32's chin wound had documentation of the size and description of the wound. The DON confirmed all the wounds should have been assessed with a description and measurement at the time they were discovered. On 7/1/21 at 6:37 p.m., during a survey team	F 686		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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F 686	Continued From page 27 meeting with the facility's Administrator and DON, Resident #32's missing/incomplete skin assessments and delayed skin treatment were discussed for a final time. No additional information was provided to the survey team about these issues.	F 686	**F-692 Nutrition/Hydration Status Maintenance** **Criteria #1** Resident #203 was reviewed by the DON, Provider as well as SLP to verify nutritional need and order clarification was initiated prior to survey exit. **Criteria #2** Residents with SLP initiated therapeutic diets were reviewed to ensure diet orders and received meals/hydration was per order and individual need. No further issues were identified. This was conducted prior to survey exit. **Criteria #3** Weekly reviews on various mealtimes for residents with SLP initiated therapeutic ordered diets will be completed for three weeks to ensure accurate diet/hydration provision. Education on diet orders will be conducted with facility clinical staff. Therapeutic diet requirement education will be provided to dietary and clinical staff to include service, order process and individual therapeutic diet components.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to offer the therapeutic diet indicated by the speech therapy assessment for 1 of 28 residents in the survey sample (Resident #203).	F 692		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 692	Continued From page 28 Resident #203 was admitted to the facility with diagnoses including cerebral infarction, essential thrombocytopenia, pneumonia, atherosclerotic heart disease, acute kidney failure, dysphagia, oropharyngeal phase, hypertension, and hemiplegia. The resident did not have a minimum data set assessment on file. On 6/29/ 2021, the resident reported that being unable to feed self due to inability to move arms. The resident's tray had a pureed diet, set up by staff. The surveyor asked the nurse if someone would help the resident and the nurse said the resident could use one arm to self feed. The resident was absent from the building on 6/30/21 from 7:30 AM to late evening. On 7/01/21 at 11:30 AM, a second nurse was unable to tell the surveyor how the resident eats or to find an assessment. On 07/01/21 at 12:09 PM, the surveyor spoke with the occupational therapist who said the resident had been assessed and was stand by assist. A therapy staff member printed the physical therapy (PT), occupational therapy (OT), and speech therapy (ST) assessments completed for the resident. The speech therapy assessment recommended pureed diet with nectar thick liquids and a straw; and close supervision while eating. On 7/1/21 at 1 PM, the occupational therapist supervised the resident's lunch. The resident self fed with cueing. The lunch tray had pureed food and thin liquids. The therapist asked a CNA to get nectar thickened liquids for the resident. The meal ticket did not reflect the need for thickened liquids.	F 692	**Criteria #4** Results of the audits, as well as results of the education will be reviewed by the facility QAPI committee for further recommendation, intervention, and/or resolution. **Criteria #5** The date of compliance for this alleged deficient practice will be July 31,2021.	

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 29 Clinical record review on 7/1/2021 revealed a physician order dated 6/25/2021 for CCD (controlled carbohydrate diet), NECTAR THICKENED LIQUID, Dys (dysphagia) Puree. The resident's baseline care plan-dietary included approaches 1- monitor for safety and assist with meals, food consumption and 2- provide diet as ordered. Monitor for safety (swallowing). The administrator and director of nursing were notified of the concern with safe feeding during a summary meeting on 7/1/2021.	F 692		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	**F-755 Pharmacy Services/Procedures/Records** **Criteria #1** Resident #2 and #33 was/is receiving an infrequently used, relatively new medication on back order with no generic equivalent available. This medication available is not stocked in the stat box (cubex). The medication was received. The MD, RP and Resident was aware of omissions. Education of staff related to omissions or unavailable medication protocols was completed prior to survey exit.	

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 30 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and clinical record review, the facility staff failed to provide pharmaceutical services by obtaining physician ordered medications for 2 of 28 residents in the survey sample (Resident #2 and #33) and failed to ensure a medication was ingested prior to leaving the resident's room for 1 of 28 residents in the survey sample (Resident #11). 1. For Resident #2, the facility staff failed to ensure the medication Briviact (an anticonvulsant drug used to treat partial-onset seizures) was available for administration. Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Epilepsy Unspecified Not Intractable without Status Epilepticus, Urinary Tract Infection Site Unspecified, Schizoaffective Disorder Depressive Type, Type 2 Diabetes Mellitus without Complications, Heart Failure Unspecified, and Bipolar Disorder. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 3/11/21 assigned the recent a BIMS (brief interview for mental status) score of 11 out of 15,	F 755	**Criteria #2** MARs of residents within the facility were reviewed prior to survey exit to identify any omitted or unavailable medications and corrective measures were taken at time of discovery. **Criteria #3** Education of clinical staff will include the components of action based upon the facility policy. MAR audits will be conducted by the DON or designee to review any documented omission or unavailable medication and subsequent follow up per protocol. Audits will be conducted 5 times per week for 4 weeks. Corrective measures will be initiated at time of discovery and noted within audit. **Criteria #4** Results of audits and education compliance will be presented to the facility QAPI committee for further intervention, recommendation, or resolution. **Criteria #5** The date of compliance for this alleged deficient practice will be July 31, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 755	Continued From page 31 indicating moderate impairment, in section C, Cognitive Patterns. In section I, Active Diagnoses, Resident #2 was coded for the diagnosis of Seizure Disorder or Epilepsy. A review of Resident #2's clinical record revealed the following documentation: A nursing progress note dated 6/08/21 9:22 am states "Called to room noted resident was having focal seizures will not answer to (his/her) name. Unable to arouse vs (vital signs) 98=85-18-148/90- O2 (oxygen) 94% on room air. Diazepam Gel 10 mg continues to have seizures. EMS called along with report to (hospital name omitted). Family also called (name omitted) made aware". Subsequent nursing progress note dated 6/08/21 2:29 pm states "Called (hospital name omitted) stated they admitted (him/her) for seizures and UTI (urinary tract infection)". An additional nursing progress note dated 6/08/21 11:06 pm states "(Hospital name omitted) called and spoke with this nurse. Resident is being transferred to (hospital name omitted) for increased seizures". Resident #2's active physician's orders at the time of discharge on 6/08/21 included an order dated 10/19/20 for Briviact (brivaracetam) tablet 100 mg by mouth twice a day for seizures. A review of Resident #2's June 2021 MAR (medication administration record) revealed that four doses of the medication Briviact was not administered prior to the resident's transfer out to the hospital on 6/08/21. Briviact was not administered on 6/06/21 10:00 am, 6/06/21 10:00 pm, 6/07/21 10:00 am, and 6/07/21 10:00 pm. The reason for the Briviact not being	F 755	**F-755 Residents Free of Significant Med Errors** **Criteria #1** Resident #49 received a comprehensive Medication order review by Pharmacist, MD, and Clinical Staff. Notifications were provided related to medication error noted. Upon Medication review immediate education for clinical staff was completed related to #49 insulin administration. Resident #5 received a comprehensive Medication order review by Pharmacist, MD, and Clinical Staff. Notifications were provided related to medication error noted. Upon Medication review immediate education for clinical staff was completed related to #5 levothyroxine administration. **Criteria #2** Residents receiving insulin and/or levothyroxine had MAR reviewed prior to survey exit to ensure accurate and appropriate administration. If issues are identified, corrective measures will be initiated at time of discovery.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

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CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 755	Continued From page 32 administered on 6/06/21 at 10:00 am was documented on the MAR as "On Hold", "awaiting arrival from pharmacy, resupply order sent. No seizure activity noted". Briviact was not administered on 6/06/21 at 10:00 pm with MAR documentation stating "on hold". Briviact was again not administered on 6/07/21 at 10:00 am with the reason documented as "Drug/Item Unavailable". Briviact was also not administered on 6/07/21 10:00 pm with the MAR stating "On hold". Resident #2's hospital admission History and Physical dated 6/09/21 3:28 am states in part, "Convulsive status epilepticus 6/08/21: Patient presenting from nursing home with prolonged convulsion with recurrent focal seizure based on clinical history. Outside hospital CT head unremarkable. Labs reveal UTI which I suspect has lowered (his/her) seizure threshold". Resident #2 was readmitted to the facility on 6/14/21. Resident #2's care plan included a problem area of diagnosis of seizure disorder with an approach to "administer medications per orders". Surveyor reviewed the listing of medications available in the facility onsite Stat Box and the facility Cubex medication supply and Briviact was not available in either onsite supply location within the facility. On 7/01/21 at approximately 8:00 am, surveyor notified the DON (director of nursing) of Resident #2 not receiving Briviact on 6/06/21 and 6/07/21 prior to their transfer to the hospital. At 11:42 am, surveyor discussed the concern with the DON	F 755	**Criteria #3** Comprehensive Clinical Education will be completed with nursing staff related to medication administration policy to include omission/unavailable meds, order verifications, 5 rights of order administration and Med Error Policy. MAR Audits will be completed 5 times per week for 4 weeks by the DON or designee, as part of the clinical meeting to ensure compliance with protocol and med administration guidelines. **Criteria #4** The results of the Audits as well as education compliance will be reviewed as part of the facility QAPI process and additional recommendations, revisions, or resolution completed as deemed necessary to maintain compliance. **Criteria #5** The date of Compliance of this alleged deficient practice will be July 31, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

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CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 755	Continued From page 33	F 755		

and administrator who stated the nurses called the pharmacy several times about the medication not being available and the pharmacy kept saying it would be on the next run.

On 7/01/21 at 9:45 am, surveyor met with UM (unit manager) #1 who stated they do have a lot of problems with the pharmacy, nurses will call and the pharmacy will say it is coming on the next run. At 12:08 pm, surveyor again spoke with UM #1 who stated they notified the nurse practitioner on 6/07/21 while in the facility that they were "having a hard time" getting the resident's medication but failed to put in a note.

Surveyor spoke with the FNP (family nurse practitioner) on 7/01/21 at 12:30 pm, who stated they did talk with UM #1 concerning Briviact and gave the instructions to call the pharmacy and let them know we need it stat. Surveyor asked the FNP if missing four administrations of Briviact caused Resident #2's seizures, FNP stated it was hard to say because the resident had acute processes going on also. FNP further stated that Briviact has a long therapeutic index and it is more likely the seizures were from the UTI.

On 7/01/21 at approximately 12:20 pm, RN #1 provided surveyor with a "Reorder Sheet for (name omitted) Pharmacy" dated 6/04/21 indicating Resident #2's Briviact was initially reordered on 6/04/21, a handwritten note on the form states "on hand 4". An attached fax confirmation sheet indicated the reorder sheet was successfully faxed to the pharmacy on 6/04/21 at 5:59 am. RN #1 also provided a copy of a "Pharmacy Communication Sheet" dated 6/06/21, under the section "Resident Name and Medication called about:" the form states in part

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 755	Continued From page 34 "(Resident #2) - Vimpat and Briviact". Under the section "Comments about call", it was documented "coming". An additional "Pharmacy Communication Sheet" dated 6/07/21 includes Resident #2's name and Briviact under the section "Resident Name and Medication called about" and under the section "Comments about call" it was documented "coming on evening run". RN #1 stated the medication was not called into the back-up pharmacy because the pharmacy kept saying it was "coming on the next run". RN #1 further stated they were having weekly calls with the pharmacy and this was a constant issue with the pharmacy. Surveyor requested and received the facility policy entitled, "Unavailable Medications" which states in part: A. The pharmacy staff shall: 1) Call or notify nursing staff that the ordered product(s) is/are unavailable. 2) Notify nursing when it is anticipated that the drug(s) will become available. 3) Suggest alternative, comparable drug(s) and dosage of drug(s) that is/are available, which is covered by the resident's insurance. B. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medication. 3) Notify the pharmacy of the replacement	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 755	Continued From page 35	F 755		

order.

On 7/01/21 at approximately 6:30 pm, surveyor notified the administrator and DON of the concern of Resident #2 not receiving Briviact as ordered prior to transfer to the hospital on 6/08/21.

No further information regarding this issue was presented to the survey team prior to the exit conference on 7/01/21.

2. The facility staff failed to ensure Resident #33's medication (Namzaric for treatment of dementia) was available for administration on 2 (two) days in June 2021. (6/02/2021 and 6/17/2021).

Resident #33's face sheet listed the resident's diagnoses included but were not limited to, type 2 diabetes mellitus, unspecified dementia with behavioral disturbance, Alzheimer's disease, anxiety disorder and cognitive communication deficit. The minimum data set (MDS) with an assessment reference date (ARD) of 5/07/2021 noted in Section C (Cognitive Patterns) the resident's brief interview for mental status (BIMS) score was 03 out of 15.

A review of Resident #33's medication administration record (MAR) revealed an order that read, "Namzaric (memantine-donepezil) capsule, sprinkle ER (extended release); 21-10 mg; Amount to Administer: 1 capsule; oral once a day for dementia." The order started 7/30/2020 with an open ended stop date. There were two days in June 2021 the medication was not administered. The MAR read on 6/02/2021 at 5:01 a.m. the medication was not administered; the dose was "on hold" and the physician was aware. The MAR read on 6/17/2021 at 5:09 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 755	Continued From page 36 the medication was not administered; the drug was unavailable. On 7/01/2021 at approximately 2:30 p.m., the facility's interim director of nursing (IDON) reported the two (2) doses of Nameric were not administered on 06/02/2021 and 06/17/2021 because the facility's pharmacy would only send enough doses for two weeks at a time. The unit manager (UM) reported when their nurses call the pharmacy, the nurses were told the medication will be sent on the next run but that did not mean the medication would arrive with the next delivery. The pharmacy, located out of town, provided two deliveries a day (one between 8 a.m. and approximately 10 a.m. and one between 10 p.m. and 1 a.m.). The IDON provided a document that noted Resident #33's Namzaric was requested by facility staff via fax from the pharmacy on 06/14/2021 and acknowledged the turn around time was longer than it should be since the medication was not available 3 (three) days later on 06/17/2021. The UM provided a pharmacy policy titled, "UNAVAILABLE MEDICATIONS" on 7/01/21 at 12:25 p.m. The policy stated the facility must make every effort to ensure medications were available to meet the needs of each resident but did not address the pharmacy's role related to the delivery of medications. The administrator and DON were informed of these findings on 7/01/2021 at 6:37 p.m. No further information was provided prior to exit. 3. The facility staff failed to ensure Resident #11 ingested an ordered medication (liquid	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 755	Continued From page 37 potassium) before leaving the resident's room. Resident #11's face sheet listed the resident's diagnoses included but were not limited to, acute respiratory failure, difficulty in walking, hypokalemia (low potassium), and chronic obstructive pulmonary disease. The minimum data set (MDS) with an assessment reference date (ARD) of 4/13/2021 noted in Section C (Cognitive Patterns) the resident's brief interview for mental status (BIMS) score was 15 out of 15. On 06/29/2021 at approximately 11:45 a.m. the surveyor observed an orange liquid in a medicine cup on Resident #11's bedside table. The resident was awake in bed and there was no one else in the room; no roommate and no facility staff. When asked, Resident #11 reported the orange liquid was potassium which she usually drank later. The surveyor requested the medication nurse (LPN #1 - licensed practical nurse) to come to the resident's bedside. LPN#1 acknowledged leaving the 15cc potassium with the resident on the bedside table because the resident usually drank it with lunch. Resident #11 stated she would drink it now and LPN#1 poured the orange liquid into a styrofoam cup filled with water that was also on the bedside table. LPN#1 then left the room prior to Resident #11 consuming any of the fluid in the cup. LPN#1 and the surveyor went to the medication cart to look up the order while LPN#1 recalled the medication was once a day, scheduled for 9:00 a.m. The nurse stated that since the resident did not like to eat breakfast, she preferred taking the medication with lunch and maybe they could change the time on the order to accommodate the resident's preference. LPN#1 was called away from the medication cart in order assist with another	F 755		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 755	Continued From page 38 resident prior to reading the order with the surveyor. On 6/29/2021 at approximately 2:35 p.m., the director of nursing (DON) and interim director of nursing (IDON) were notified of the above described observation. Resident #11's clinical record was reviewed. The director of nursing provided a copy of Resident #11's physician's orders that he acknowledged governed the potassium chloride medication for 6/29/2021 a.m. The physician order with a start date of 4/05/2021 and an open ended stop date read "potassium chloride liquid; 20 mEq/15 ml; amt: 15 ML; oral [DX: Hypokalemia] Twice A Day; 09:00 AM, 09:00 PM." On 6/30/2021 at 2:25 p.m., the DON provided a policy titled, "Administering Oral Medications" which read in part, "21. Remain with the resident until all medications have been taken." The administrator and the DON were informed of the aforementioned observation during a meeting on 7/01/2021 at 6:37 p.m. No further information was provided prior to exit.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure that residents were free of	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 760	Continued From page 39	F 760		

significant medication errors for 2 of 28 residents in the survey sample, Residents #49 and #5.

1. For Resident #49, the facility staff failed to follow physician's orders for the administration of Novolog (a rapid-acting insulin) on five separate occasions.

Resident #49's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus without Complications, Cerebral Palsy Unspecified, Unspecified Dementia without Behavioral Disturbance, Schizophrenia Unspecified, and Barrett's Esophagus without Dysplasia.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/13/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15, indicating severe impairment, in section C, Cognitive Patterns. In section I, Active Diagnoses, Resident #49 was coded for the diagnosis of Diabetes Mellitus.

Resident #49's active physician's orders included the following orders each dated 5/19/21: Novolog U-100 Insulin aspart solution 100 unit/ml 5 units subcutaneously before breakfast hold if blood sugar is less than 160 and notify MD and Novolog U-100 Insulin aspart solution 100 unit/ml 8 units before lunch and dinner hold if blood sugar is less than 160 and notify MD.

A review of Resident #49's June 2021 MAR (medication administration record) revealed the resident received Novolog 8 units on 6/07/21 at 5:30 pm with a documented blood sugar of 153. On 6/26/21 at 6:30 am, the resident received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 760	Continued From page 40 Novolog 5 units with a documented blood sugar of 122. On 6/28/21 at 6:30 am, the resident received Novolog 5 units with a documented blood sugar of 154. Resident #49's Novolog was held on 6/02/21 at 5:30 pm with a documented blood sugar of 160 and on 6/27/21 at 5:30 pm with a documented blood sugar of 160. Resident #49's current care plan includes a problem area stating "I am at risk for complications associated with hyper- or hypoglycemia related to DX (diagnosis) of Diabetes Mellitus" with an approach to "administer medications as ordered by my physician". On 6/30/21 at approximately 3:35 pm, surveyor notified the administrator and director of nursing of the concerns of the staff failing to follow the physician's orders for Novolog administration for Resident #49. No further information regarding this issue was presented to the survey team prior to the exit conference on 7/01/21. 2. For Resident #5, facility staff failed to administer the thyroid medication levothyroxine as ordered. Resident #5 was admitted to the facility with diagnoses including dementia, hypertension, diabetes mellitus, renal disease, thyroid disorder, anxiety, depression, and psychotic disorder. On the minimum Data Set assessment with assessment reference date 3/19/21, the resident scored 12/15 on the brief interview for mental status and was assessed as without signs of	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 760	Continued From page 41 delirium, psychosis or behavior affecting care. During clinical record review on 7/1/2021, the surveyor noted a physician order dated 4/21/2021 for levothyroxine tablet; 25 mcg (microgram) once a day at 6 AM. Review of the medication administration record (MAR) revealed notes on 5/8, 5/9, 6/1, and 6/2 "Not administered: On Hold Comment: md aware". The surveyor requested nursing progress notes for May and June 2021. No nursing note addressed the absence of the medication, notification of the physician, or attempts to obtain the medication for the resident. On 7/1/2021 at 9:40 AM, the surveyor interviewed LPN #1 about the procedure for obtaining medications not in the resident's regular supply. LPN reported that there was a stat box and the Cubex machine which could dispense single doses of medication with a code from the pharmacy. At 10 AM, LPN #2, on the resident's nursing unit, showed the surveyor the stat box. The list indicated that it held 3 doses of the levothyroxine. LPN #2 located the medication bag and discovered it contained 4 doses of levothyroxine 25 mcg. LPN #2 stated the box was replaced at least every two weeks. The surveyor determined that the medication would have been available from the stat box on the dates it was not administered. The administrator, director of nursing, and assistant director of nursing were notified of the concern during a summary meeting. No additional information was offered about the failure to administer levothyroxine on the four	F 760		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 42 dates. Levothyroxine on hold MD aware 6/1 and 6/2; 5/8 and 5/9. F 812 Food Procurement,Store/Prepare/Serve-Sanitary SS=F CFR(s): 483.60(i)(1)(2) §483.60(l) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to meet safety requirements by storing food that reflected expired use by dates and boxes of unfrozen ice cream. The findings included: During initial tour of the facility, the surveyor observed food in the active food supply with expired use by dates and observed two boxes of	F 760 F 812	**F-812 Food Safety Requirements** **Criteria #1** Food with noted expiration date as well as thawed ice cream was immediately discarded upon discovery, and prior to survey exit. **Criteria #2** Comprehensive food storage inspection was completed immediately and any expired items, or issues identified with storage was addressed at time of discovery. This item was completed prior to survey exit and no other issues were identified. **Criteria #3** Education of facility staff related to food safety requirements, procurement, storage, and labeling/dating/expiration of food will be provided. Weekly inspections of the food storage areas will be completed by the food service manager and verified by the Administrator weekly for 4 weeks. Any issue identified will be corrected at time of discovery and noted on audit tool.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 812	Continued From page 43 ice cream in the freezer that were not frozen. 06/29/21 11:00 a.m., the surveyor checked the nourishment refrigerator with the accounts manager in dietary. The surveyor observed almond milk with an open date of 05/27/21 and a use by date of 06/03/21, five bottles of lemon juice with an open date of 05/13/21 and a use by date of 06/13/21, one bottle of thousand island dressing open date 05/28/21 use by date 06/04/21, a silver deep dish tray that contained smuckers topping (no open date), raspberry topping with an open date of 05/05/21 and a use by date of 06/05/21, caramel topping and chocolate topping with no open date. The outside of this tray had a sticker that read open date 05/07/21 use by date 06/07/21. The accounts manager identified these items as belonging to the activities department. The walk in freezer contained two boxes of ice cream that were not frozen. The dry storage included six bottles of lemon juice with a best buy date of 09/19/20 and two jugs of salsa with a best buy date of 02/07/2021. 06/30/21 3:34 p.m., the administrator and (DON) director of nursing were made aware of the issues in the dietary department. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 812	**Criteria #4** Results of audits and educational compliance will be presented to the facility QAPI committee for further evaluation, recommendation, revisions, or resolution to maintain compliance. **Criteria #5** The date of compliance set for this alleged deficient practice will be July 31, 2021.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880	**F-880 Infection Control and Prevention**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 880	Continued From page 44 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880	**Criteria #1** Resident #57 and #58 is no longer on isolation precautions and does not meet criteria for such. The nurse for #75 that touched medication with bare hands received immediate education and counseling related to medication administration and infection control. The Nursing Assistant observed entering room without PPE received immediate education and counseling prior to survey exit. **Criteria #2** Residents were reviewed to identify anyone meeting criteria or having a diagnosis to support isolation precautions. No resident required adding or removing precautions at time of review. Nursing staff received "cart side" education related to infection control practices with Med Pass and Prep. No further issues were identified at time or review or education. All Nursing staff received additional PPE education and review. **Criteria #3** Review of admissions, readmissions and changes of conditions will be conducted for 4 weeks to evaluate compliance with isolation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 880	Continued From page 45 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility staff failed to ensure an effective infection control program for 3 of 28 residents (Resident #57, Resident #75, and Resident #58) and 1 of 2 units. The findings included: 1. For Resident #57 the facility staff failed to maintain contact precautions after the resident was diagnosed with MRSA (methicillin resistant staphylococcus aureus) infection.	F 880	precaution protocols. Comprehensive education will be completed related to isolation precautions as well as infection control practices with med prep and administration. Staff observations will be completed by DON and Administrator or designee to evaluate appropriate PPE usage. Immediate correction when/if issues are identified will be completed at time of discovery. **Criteria #4** The results of the audits and observations, as well as education compliance and effectiveness will be reviewed by the facility QAPI committee and further evaluation, reviews, recommendations, and/or resolution will be determined at that time. **Criteria #5** The date of compliance for this alleged deficient practice will be July 31, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 880	Continued From page 46 Resident #57's face sheet listed diagnoses which included but not limited to pyelonephritis, ESBL (extended spectrum beta lactamase) resistance, urinary tract infection, hypertension, atrial fibrillation, type II diabetes mellitus, depression, sepsis, MRSA (methicillin resistant staphylococcus aureus) and chronic kidney disease. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/20/21 assigned the resident a BIMS (brief interview for mental status) 12 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Resident #57's comprehensive care plan was reviewed and contained a care plan for "Risk for infection R/T (related to) multiple chronic disease processes and communal living environment". Resident #57's clinical record was reviewed and contained a signed physician's order summary for 06/15/21-06/30/21, which read in part "General 06/12/2021-Open-Ended ON ISOLATION FOR MRSA IN PICC (peripherally inserted central catheter) LINE" and "Prescription 06/12/2021-06/27/2021 BACTRIM caplet; 800 mg; amt: 1; oral Special Instructions: BACTRIM 800 mg PO x 14 DAYS FOR MRSA Twice A Day; 09:00 AM, 09:00 PM" Surveyor observed Resident #57 on 06/29/21 at approximately 4:20 pm. Resident in private room. No contact precaution signage noted on resident's door and no isolation cart observed. Surveyor spoke with CNA (certified nurse's aide) #1 on 06/29/21 at approximately 4:25 pm and	F 880		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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F 880	Continued From page 47	F 880		

asked CNA #1 if Resident #57 was on contact precautions and CNA #1 stated that they were not.

Surveyor spoke with LPN (licensed practical nurse) #1 on 06/29/21 at approximately 4:35 pm. Surveyor asked LPN #1 if Resident #57 is on precautions and LPN #1 stated they are not. LPN #1 stated resident came back from hospital on 06/11/21. On 06/12/21, the hospital called and said they had pulled the resident's PICC line and it grew MRSA. LPN #1 stated they put her on contact precautions, but on Monday (06/14), the unit manager, told them the resident did not need to be on precautions, so "I took it down". Surveyor asked LPN #1 if they had called the Dr to confirm the orders, and LPN #1 stated they had not. Surveyor asked LPN #1 if they should have and LPN #1 stated that they should. Surveyor asked LPN #1 if they had discontinued the contact precaution order and LPN #1 stated they had not.

Surveyor spoke with ICP (infection control preventionist) on 06/29/21 at approximately 4:45 pm. Surveyor asked ICP if the resident should have been on contact precautions and ICP stated that the resident should have been on precautions.

Surveyor spoke with Dr. ... (name omitted), the facility medical director, on 06/30/21 at approximately 1:20 pm. Surveyor asked the medical director if they had been notified of resident's PICC line having grown MRSA, and medical director stated they had no information on this. Medical director stated that facility staff should have called for directions and stop date for contact precautions. Medical director stated that resident should have remained on contact

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 880	Continued From page 48	F 880		

precautions for the duration of treatment "even though the risk of spread is low". Medical director also stated, "There was no mention to me that she had grown MRSA. Been nice to have blood cultures." Surveyor asked medical director if the facility staff had confirmed the Bactrim order with them, and physician stated they had not.

The concern of the facility staff not maintaining contact precautions was discussed during a meeting with the administrative staff during a meeting on 07/01/21 at approximately 6:35 pm.

No further information provided prior to exit.
2. For Resident #75, the nursing staff was observed to touch the residents medications with their bare hands prior to administering.

06/30/2021 8:10 a.m., during a medication pass and pour observation with (LPN) licensed practical nurse #1. This nurse was observed by the surveyor to remove three medications from medication cards, place these medications into their bare hands, and then place the medications into the medication cup. LPN #1 was also observed to drop a medication onto the top of the medication cart, pick it up with their bare hands, place the medication into the medication cup and administer these medications to the resident.

06/30/21 8:19 a.m., LPN #1 verbalized to the surveyor that they had touched the medications with their bare hands and they knew better than to do that.

06/30/2021 2:45 p.m., LPN #1 verbalized to the surveyor that she had cleaned her medication cart with a disinfectant wipe prior to beginning their medication pass and completed hand

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 49	F 880		

hygiene before and after each resident. The surveyor observed this nurse to use hand sanitizer after administering this residents medications.

Facility policy titled, "Administering Oral Medications." This policy read in part, "...For unit dose tablets or capsules. Place packaged medications directly into the medication cup..."

06/30/21 10:59 a.m., the (IP) infection preventionist was made aware that LPN #1 had touched resident medication prior to administration during the medication pass and pour observation. The IP verbalized to the surveyor that they would be providing re-education to the nursing staff.

06/30/21 3:34 p.m., the administrator and (DON) director of nursing were made aware of the infection control issue during the medication pass and pour observation.

No further information regarding this issue was provided to the surveyor prior to the exit conference.

3. For Resident #58, the facility staff failed to obtain a physician's order to place the resident on transmission based precautions for a diagnosis of c. diff (Clostridioides difficile) infection and failed to notify the dialysis center of the resident's diagnosis of c. diff.

Resident #58's diagnosis list indicated diagnoses, which included, but not limited to End Stage Renal Disease, Chronic Diastolic Congestive Heart Failure, Type 2 Diabetes Mellitus without Complications, and Bipolar Disorder Unspecified.

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 880	Continued From page 50	F 880		

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 5/26/21 assigned the resident a BIMS (brief interview for mental status) score of 13 out of 15 in section C, Cognitive Patterns.

A review of Resident #58's clinical record revealed the following documentation:

A nursing progress note dated 5/31/21 6:04 pm states in part, "goes to dialysis M, W, F" and "positive for CDIFF, (name omitted) NP (nurse practitioner) notified, awaiting new orders".

A 6/03/21 11:50 am social services progress note states in part, "SW (social worker) informed resident that (he/she) was being moved to room (omitted) and being taken off of isolation".

Surveyor reviewed Resident #58's physician's orders from 5/31/21 to 7/01/21 and was unable to locate a physician's order to place the resident on transmission based precautions for c. diff infection. Surveyor was also unable to locate documentation in the resident's clinical record of notification to the dialysis treatment center of the resident's diagnosis of c. diff.

On 7/01/21 at approximately 4:00 pm, surveyor spoke with the Infection Control Nurse who stated that Resident #58 no longer requires isolation for c. diff as their antibiotic has completed. The Infection Control Nurse also stated that isolation for c. diff ends when the antibiotic treatment is completed. According to Resident #58's June 2021 MAR (medication administration record), the last ordered dose of the antibiotic, Vancomycin, was administered on 6/17/21.

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 51 Surveyor requested and received the facility policy entitled, "Clostridium Difficile" which states in part, "Residents with diarrhea associated with C. difficile (i.e., residents who are colonized and symptomatic) are placed on Contact Precautions". On 7/01/21 at approximately 6:30 pm, surveyor notified the administrator and director of nursing of the concern of Resident #58's diagnosis of c. diff and being unable to locate a physician's order for isolation precautions or documentation of dialysis treatment center notification of the diagnosis. No further information regarding these issues were presented to the survey team prior to the exit conference on 7/01/21. 4. Facility staff failed to wear appropriate personal protective equipment when entering rooms of residents on contact precautions. 07/01/21 06:02 PM CNA entering contact isolation rooms without PPE. On 7/1/2021 at 1 PM, the surveyor observed lunch service on the hall containing rooms 100 through 111. Residents in eight of those rooms were on contact precautions to observe for symptoms of Covid-19 after admission to the facility. Signage on the doors indicated the rooms where residents were on contact precautions. The surveyor observed CNA #1 wearing a surgical mask delivering and setting up lunch trays to rooms. The CNA did not don gown, gloves, N95 mask and eye protection on entering the isolation rooms. The surveyor observed CNA #1 exit room 102 (not isolation), enter Room 103 (isolation),	F 880		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 52 retrieve thickened liquids and re-enter 103, enter 104 (isolation) and set up tray, then enter 107 (not isolation). The aid was not observed to perform hand hygiene at any time. While the CNA was in room 104, the speech therapist exited room 103. The surveyor asked the speech therapist to look at the aid, who was clearly visible from the hallway and facing the door, if the aid was wearing appropriate PPE. The speech therapist stated the aid was not. As the CNA exited room 107, a LPN stopped the aid, stating that a N95 mask was required and led the aid down the hall to find one. The surveyor still had not observed the CNA perform hand hygiene. The administrator and director of nursing were notified of the concern during a summary meeting on 7/1/2021.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F 883	**F-883 Influenza and pneumococcal immunizations** **Criteria #1** Resident #17 and #70 received extensive medical records reviews prior to admission as well as approved contact interviews to determine desire, receipt and need for vaccine. Resident #70 did not want vaccine at this time. Resident #17 requested to wait until closer to official flu season as they had received the covid vaccine. Risk and benefits were discussed, and education provided and documented prior to survey exit. Survevor was notified of status.	

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

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F 883	Continued From page 53 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff	F 883	**Criteria #2** Comprehensive resident review was conducted by Medical Records to ensure complete Flu and Pneumococcal records prior to survey exit. Surveyor was notified of status. **Criteria #3** Staff education will be completed related to the facility flu and pneumococcal vaccination protocol by Administrator, ADON or designee. Admissions and readmissions will be reviewed to ensure completion of consents/declination and provision of vaccines by Admission Director and DON or designee monthly for three months. **Criteria #4** Results of the audits and education compliance and any issue identified therein will be reviewed by the facility QAPI committee for further recommendation, revision, evaluation and/or resolution. **Criteria#5** The date of Compliance for this alleged deficient practice will be July 31, 2021.	

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 54 failed to assess pneumococcal immunization status and/or address pneumococcal immunization needs for two (2) of five (5) residents sampled for immunization review (Resident #17 and Resident #70). The findings include: The facility staff members failed to address Resident #17's and Resident #70's pneumococcal immunization status and/or pneumococcal immunization needs. Review of Resident #17's and Resident #70's clinical documentation failed to reveal evidence of the residents' pneumococcal status being assessed by facility staff members. Resident #17's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/12/21, had the resident assessed as able to make self understood and as able to understand others. Resident #17's Brief Interview for Mental Status (BIMS) summary scare was documented as five (5) out of 15. Resident #17 was documented as requiring assistance with transfers, bed mobility, dressing, toilet use, and personal hygiene. Resident #17's diagnoses included, but were not limited to: high blood pressure, dementia, and chronic pain. Resident #70's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 6/2/21, had the resident assessed as able to make self understood and as usually able to understand others. Resident #70's Brief Interview for Mental Status (BIMS) summary score was documented as a three (3) out of 15. Resident #70 was documented as requiring	F 883		

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	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 883	Continued From page 55	F 883		

assistance with bed mobility, dressing, and personal hygiene. Resident #70's diagnoses included, but were not limited to: anemia, high blood pressure, heart disease, dementia, and lung disease.

A facility policy titled "Pneumococcal Vaccine" (with a revised date of December 2012) included the following information:
- "Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax® (pneumococcal vaccine,) and when indicated, will be offered the vaccine within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated."
- "Assessment of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission."

Resident #17's and Resident #70's "INFORMED CONSENT FOR PNEUMOCOCCAL VACCINE" forms had been signed giving consent for the residents to receive the pneumococcal vaccine. No documentation of administration of the pneumococcal vaccine for either resident was found by or provided to the surveyor.

On 6/30/21 at 2:51 p.m., the ADON stated they was unable to find documentation of pneumococcal vaccination status for the two (2) aforementioned residents.

On 6/30/21 at 3:34 p.m., the failure of facility staff members to assess and/or address Resident #17 and Resident #70 pneumococcal vaccine status/needs was discussed during a survey team meeting which included the facility's Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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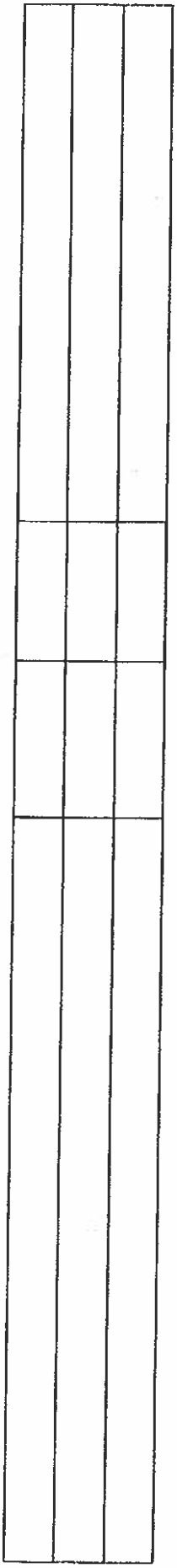
F 883	Continued From page 56 and Director of Nursing (DON).	F 883		

Directed Plan of Correction

ISSUE/CONCERN F-880 Infection Control and Prevention	Date 7/20/2021
Root Cause Analysis/Related Factors – What were the reasons/related factors for the identified opportunity, risk, or deficient practice? • Knowledge Deficit	Project Team C. Williams, RN, NHA - PoC A
Goals/Objectives/Expected Outcome • Compliance with Regulatory Compliance as related to Infection Control and Prevention (F-880)	
QAPI Committee Approval [signature / date] [signatures], Ashley [illegible], Shauna McCabe, Sharon [illegible]	
Governing Body Representative [signature / date] [signature] NHA	

Action(s) Planned	Responsible Person(s)	Projected Completion Date	Review [Date & Status Report] ▪ Use this column to demonstrate review and completion of each action/task ▪ Continue to use this column to document your monitoring outcomes
SYSTEM CHANGES: List each action separately (add additional rows if needed). Develop SYSTEM CHANGE FOR EACH ROOT CAUSE. Include any directed inservices.			
* see attached for specific process		7/31/2021	
MONITORING/QA OVERSIGHT: To track completion of system changes and to evaluate outcome of the implemented systemic changes. Include QAPI Committee oversight.			



Carrington Place at Rural Retreat
Directed Plan of Correction

Overview: Based upon observation, staff interview, clinical record review and facility document review the facility staff failed to ensure an effective infection control program for 3 of 28 resident and on 1 of 2 observed units. The alleged deficient practice was directly related to 1. Failure to maintain contact precautions after the resident was diagnosed with MRSA infection. 2. Handling medications with "bare hands" prior to medication administration. 3. Failure to obtain a physician's order to place the resident on transmission-based precautions for diagnosis of c-diff, 4. Failure to wear appropriate PPE prior to entering residents' room on contact precautions.

Root Cause Analysis synopsis: The facility QAPI committee including Administrator, Medical Director, DON, Infection Control Nurse, and other departments conducted a review of each alleged deficiencies and the following conclusions were made:

1. In the incident of failure to maintain contact precautions after the resident was diagnosed with MRSA infection, the root cause analysis of the alleged deficient practice was determined as a generalized knowledge deficiency related to qualifying diagnosis for contact precautions. Based upon facility conducted staff interviews, there was noted confusion with staff related to which diagnoses justified the use of precautions and which precautions were necessary based upon these diagnoses.
    a. Plan of Correction for the specific determined root cause:
        i. Education: Facility staff will receive Infection Prevention Education specifically targeting use of isolation and/or contact precautions as well as type of precautions, criteria for initiation, required PPE for each type of precaution, as well as signage and notifications.
        ii. Monitoring/Auditing: The Director of Nursing and Infection Control Nurse will conduct Diagnosis Based Audits weekly for 2 months, to evaluate appropriate precautions are utilized, appropriate PPE as well as correct signage and notifications. Corrective Measures, if deemed necessary through monitoring will be initiated at time of discovery.
        iii. The Director of Nursing and Infection Control Nurse will present the findings of ongoing monitoring to the QAPI committee for additional recommendations or conclusion/resolution.
2. In the incident of nurse observed touching medications with "bare hands" prior to administration, the root cause analysis of the alleged deficient practice was determined as a compliance issue and knowledge deficiency related to the observed individual is a new graduate nurse who was extremely nervous as she had never been observed with med pass by a surveyor or regulatory agent.
    a. Plan of Correction for the specific determined root cause:
        i. Education and Counseling: The Director of Nursing and Assistant Director of Nursing conducted one on one education with the specific nurse related to maintaining infection control practices during medication pass as well as the 5 rights of medication administration. The nurse will be observed monthly for 3

months by DON or ADON to assist with alleviating the nervousness of med pass observations.

ii. Med Pass observations will be scheduled and conducted for nursing staff to by DON, ADON, or Pharmacy Consultant specifically monitoring for breech in infection control practices. If breeches are identified, corrective measures will be initiated at time of discovery.

iii. The Director of Nursing and Assistant Director of Nursing will present the findings of education and counseling as well as med pass observations to the QAPI committee for further recommendation or conclusion/revision.

3. In the incident of the failure of the facility to obtain a physician order for precautions related to the root cause analysis of the alleged deficient practice was determined as both a compliance issue related to notification of dialysis center and knowledge deficiency related to the need for isolation order and notification of dialysis center.
    a. Plan of correction for the specific determined root cause:
        i. Education: Staff will receive education related to the obtaining orders for any transmission-based precautions as well as notification of appropriate parties when transmission-based precautions are necessary. Education will be provided by the Director of Nursing and Infection Control Nurse.
        ii. Monitoring: Audits will be completed with residents requiring transmission-based precautions specifically focused on receiving order for specific precaution as well as notification of appropriate parties weekly for three weeks. Initiation of specific precautions are being monitored and addressed in beforementioned corrective plan.
        iii. The Director of Nursing and Infection Control Nurse will present the findings of education and monitoring to the QAPI committee for further recommendation or conclusion/resolution.
4. In the incident of staff being observed without using appropriate PPE and transmission-based precautions the root cause of the alleged deficient practice was determined as staff compliance issue as evidenced by all appropriate signage was in place, PPE was available and observed staff recognized knowledge of transmission-based precautions and appropriate use of PPE.
    a. Plan of Correction for the determined root cause:
        i. Education and Counseling: Individual Staff member will receive one-on-one education and counseling related to transmission-based precautions. Comprehensive staff re-education related to appropriate use of PPE and Transmission based precautions will be provided to facility staff by Director of Nursing, ADON, and Infection Control Nurse.
        ii. Monitoring: Staff observations will be conducted by Infection Control Nurse to evaluate appropriate use of PPE based upon specific type of Transmission based precaution. This will be completed weekly for three weeks with immediate corrective measures made if breeches in protocol is observed.
        iii. The Infection Control Nurse will present the findings of education and monitoring to the QAPI committee for further recommendation and conclusion/resolution.

The contents of the Directive Plan of Correction will be completed, and date of compliance will be accepted as July 31, 2021.

7/25/2021

Chad E. Williams, RN, LNHA Date
Facility Representative