DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTR			PLETED
		495386	B. WING _				C <b>27/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET AD	DDRESS, CITY, STATE, ZIP CODE		
	TON PLACE AT BOTETO			290 COMN	IONS PARKWAY		
CARRING	TON PLACE AT BOTEIC	JURT COMMONS		DALEVIL	LE, VA 24083		
(X4) ID	-	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORR		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP		COMPLETION DATE
IAG		,			DEFICIENCY)	 	
E 000	Initial Comments		EO	000			
		nergency Preparedness					
		d 5/25/21 through 5/27/21.					
		red for compliance with 42					
		quirement for Long-Term complaint was investigated					
	during the survey.	complaint was investigated					
E 004		view and Update Annually	EO	04			
SS=C							
	§403.748(a), §416.54 §441.184(a), §460.84 §483.475(a), §484.10 §485.625(a), §485.72 §486.360(a), §491.12	(a), §482.15(a), §483.73(a), )2(a), §485.68(a), ?7(a), §485.920(a),					
	Federal, State and loo preparedness require develop establish and emergency prepared requirements of this s	ments. The [facility] must d maintain a comprehensive ness program that meets the section. The emergency m must include, but not be					
	and maintain an eme	The [facility] must develop rgency preparedness plan d], and updated at least lan must do all of the					
	CAH] must comply wi State, and local emer requirements. The [h develop and maintain	ency Plan. The [hospital or ith all applicable Federal, gency preparedness iospital or CAH] must					
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

06/25/2021

PRINTED: 12/30/2021

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		495386	B. WING				C 27/2021
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARRING	TON PLACE AT BOTETO	URT COMMONS		:	290 COMMONS PARKWAY		
					DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 004	Plan. The LTC facility an emergency prepar reviewed, and update * [For ESRD Facilities Plan. The ESRD facil maintain an emergen must be [evaluated], a years. This REQUIREMENT by: Based on staff interv documentation review ensure that the Emergian was reviewed an The facility plan did n that occurred after 10 changes in the reside Administrator, the Re Party Letter regarding Region Emergency C Memorandum of Und Participating Facility. The Findings included On 5/25/21, a review Emergency Prepared revision on 10/22/18, subsequent review ar Residents and Respon	t §483.73(a):] Emergency must develop and maintain edness plan that must be d at least annually. at §494.62(a):] Emergency ity must develop and cy preparedness plan that and updated at least every 2 is not met as evidenced iew and facility y, the facility staff failed to gency Preparedness (EP) id updated annually. of document the changes /22/18. This included nt population, a new sident and Responsible g EP review, the Eastern ontact List, and the erstanding (MOU) with a d: was conducted of the ness Plan. Since the there was no evidence of a ind revision. The letter sent to nsible Parties was dated	E	004			
	Residents and Respo						

Facility ID: VA0388

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495386	B. WING				27/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARRING	TON PLACE AT BOTETO	OURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 004 E 013 SS=C	Eastern Region Emer dated 3/22/19. The Administrator sta find the documentation she had been hired n She was unable to sta of any updates to the population, Eastern R Family Notification, on MOU. Development of EP P	e 2 lity was dated 3/16/18. The gency Contact List was ted that she was unable to on. She further stated that ear the beginning of 2021. ate or identify documentation plan based on the resident tegion Emergency Contacts, r the Participating Facility Policies and Procedures		004			
	§483.475(b), §484.10 §485.625(b), §485.72 §486.360(b), §491.12 (b) Policies and proced develop and impleme policies and procedur plan set forth in parage and the communication this section. The poli be reviewed and updat *[For LTC facilities at procedures. The LTC implement emergence procedures, based or forth in paragraph (a) assessment at parage and the communication	<ul> <li>(b), §482.15(b), §483.73(b),</li> <li>(2(b), §485.68(b),</li> <li>(7(b), §485.920(b),</li> <li>(b), §494.62(b).</li> <li>edures. [Facilities] must nt emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least every 2 years.</li> <li>§483.73(b):] Policies and facility must develop and y preparedness policies and n the emergency plan set</li> </ul>					

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME					FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495386	B. WING	B. WING			C 27/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		STREET ADDRESS, CITY, STATE, ZIP CODE		
CARRINGTON PLACE AT BOTETOUR	BOTETOURT COMMONS 290 COMMONS PARKWAY DALEVILLE, VA 24083					
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
<ul> <li>policies and procedures, plan set forth in paragrap and the communication this section. The policie address management of emergencies, including, equipment, power, or wa emergencies; and natura threaten the health or sa staff, or the public. The must be reviewed and u years.</li> <li>*[For ESRD Facilities at procedures. The dialysia and implement emergencies, based of set forth in paragraph (a assessment at paragraph and the communication this section. The policie be reviewed and update These emergencies including.</li> </ul>	as for PACE and ESRD b):] Policies and organization must emergency preparedness , based on the emergency ph (a) of this section, risk h (a)(1) of this section, plan at paragraph (c) of s and procedures must f medical and nonmedical but not limited to: Fire; ater failure; care-related al disasters likely to affety of the participants, policies and procedures pdated at least every 2 §494.62(b):] Policies and s facility must develop cy preparedness policies on the emergency plan ) of this section, risk h (a)(1) of this section, plan at paragraph (c) of s and procedures must d at least every 2 years. ude, but are not limited wer failures, care-related ply interruption, and o occur in the facility's	E	013			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/30/2021 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		· · ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495386	B. WING				C 27/2021
	ROVIDER OR SUPPLIER	DURT COMMONS		2	TREET ADDRESS, CITY, STATE, ZIP CODE 190 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
	documentation review ensure that the Emer Policies and Procedu updated annually. The facility staff failed Emergency Prepared Procedures. The Findings included On 5/25/21, a review Policies and procedu 10/22/18, there was r review and revision. The Administrator sta find the documentation she had been hired in She was unable to st of updated policies and EP Training and Testi CFR(s): 483.73(d) §403.748(d), §416.54 §441.184(d), §460.84 §485.625(d), §485.72 §486.360(d), §491.12 *[For RNCHIs at §403 Hospice at §418.113, at §460.84, Hospitals §485.920, OPOs at §	v, the facility staff failed to gency Preparedness (EP) res were reviewed and d to review and update the lness (EP) Policies and d: was conducted of the EP res. Since the revision dated no evidence of a subsequent ted that she was unable to on. She further stated that ear the beginning of 2021. ate or identify documentation nd procedures. ing 4(d), §418.113(d), 4(d), §482.15(d), §483.73(d), 02(d), §485.68(d), 27(d), §485.920(d),		013			

Facility ID: VA0388

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/30/2021 MAPPROVED D. 0938-0391
STATEMENT O	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495386	B. WING			C 05/27/2021		
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE			
CARRING	TON PLACE AT BOTETO			:	290 COMMONS PARKWAY			
					DALEVILLE, VA 24083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
E 036	Continued From page must develop and ma	iintain an emergency	E	036	6			
	based on the emerge paragraph (a) of this s paragraph (a)(1) of th procedures at paragra	g and testing program that is ncy plan set forth in section, risk assessment at is section, policies and aph (b) of this section, and an at paragraph (c) of this						
	section. The training be reviewed and update	and testing program must ated at least every 2 years. §483.73(d):] (d) Training						
	and testing. The LTC maintain an emergen and testing program t	facility must develop and cy preparedness training						
	section, risk assessm this section, policies a (b) of this section, and paragraph (c) of this s	then at paragraph (a)(1) of and procedures at paragraph d the communication plan at section. The training and be reviewed and updated at						
	testing. The ICF/IID n an emergency prepar program that is based forth in paragraph (a) assessment at paragr	3.475(d):] Training and nust develop and maintain redness training and testing d on the emergency plan set of this section, risk raph (a)(1) of this section, res at paragraph (b) of this						
	section, and the comparagraph (c) of this stesting program must least every 2 years. T							
	-	at §494.62(d):] Training, on. The dialysis facility must						

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	-	ID HUMAN SERVICES				FORM	APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLI	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED		
		495386	B. WING				C	
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	05/	27/2021	
	TON PLACE AT BOTETO				290 COMMONS PARKWAY			
CARRING	ION PLACE AT BOTETC		DALEVILLE, VA 24083					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE			
E 036 E 037 SS=C	section, risk assessm this section, policies a (b) of this section, and paragraph (c) of this section, and paragraph (c) of this section, and updated at every 2 yet This REQUIREMENT by: Based on staff intervi- documentation review ensure that the Emerg Training and Testing F and updated annually The facility staff failed Emergency Prepared Testing Program. The Findings included On 5/25/21, a review Training and Testing F revision dated 10/22/ an annual review and The Administrator sta find the documentation she had been hired m She was unable to sta of updated training ar EP Training Program CFR(s): 483.73(d)(1)	an emergency g, testing and patient hat is based on the borth in paragraph (a) of this ent at paragraph (a)(1) of and procedures at paragraph d the communication plan at section. The training, testing am must be evaluated and ears. T is not met as evidenced iew and facility w, the facility staff failed to gency Preparedness (EP) Program had been reviewed t. I to review and update the ness (EP) Training and d: was conducted of the EP Program. Subsequent to the 18, there was no evidence of revision. ted that she was unable to on. She further stated that ear the beginning of 2021. ate or identify documentation		036				
	§403.748(d)(1), §416	.54(d)(1), §418.113(d)(1),						

Facility ID: VA0388

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	· /		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495386	B. WING				27/2021
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CARRING	TON PLACE AT BOTETC	OURT COMMONS	290 COMMONS PARKWAY DALEVILLE, VA 24083				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
E 037	<ul> <li>§441.184(d)(1), §460</li> <li>§483.73(d)(1), §483.4</li> <li>§485.68(d)(1), §485.4</li> <li>§485.920(d)(1), §485.4</li> <li>§485.920(d)(1), §486.4</li> <li>*[For RNCHIs at §403</li> <li>Hospitals at §482.15, at §484.102, "Organiz</li> <li>OPOs at §486.360, R</li> <li>(1) Training program the following:</li> <li>(i) Initial training in empolicies and procedure staff, individuals provia arrangement, and vol expected roles.</li> <li>(ii) Provide emergence least every 2 years.</li> <li>(iii) Maintain documer preparedness training</li> <li>(iv) Demonstrate staff procedures.</li> <li>(v) If the emergency procedures are signiff must conduct training procedures.</li> <li>*[For Hospices at §41 hospice must do all or (i) Initial training in empolicies and procedur</li> <li>services under arrange expected roles.</li> <li>(ii) Demonstrate staff procedures.</li> </ul>	84(d)(1), §482.15(d)(1), 75(d)(1), §484.102(d)(1), 625(d)(1), §485.727(d)(1), 360(d)(1), §491.12(d)(1). 8.748, ASCs at §416.54, ICF/IIDs at §483.475, HHAs rations" under §485.727, HC/FQHCs at §491.12:] The [facility] must do all of mergency preparedness res to all new and existing ding services under unteers, consistent with their y preparedness training at matation of all emergency breparedness policies and cantly updated, the [facility] on the updated policies and 8.113(d):] (1) Training. The	E	037	7		

Facility ID: VA0388

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/30/2021 RM APPROVED NO: 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495386	B. WING _			C 05/27/2021		
NAME OF P	ROVIDER OR SUPPLIER		· [	STR	EET ADDRESS, CITY, STATE, ZIP CODE			
CARRING	TON PLACE AT BOTETO	OURT COMMONS			COMMONS PARKWAY LEVILLE, VA 24083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 037	employees (including special emphasis play procedures necessar others. (v) Maintain documer preparedness training (vi) If the emergency procedures are signif must conduct training procedures. *[For PRTFs at §441. program. The PRTF r (i) Initial training in en policies and procedur staff, individuals prov arrangement, and vol expected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain documer preparedness training (v) If the emergency p procedures are signif must conduct training procedures. *[For PACE at §460.8 organization must do (i) Initial training in en policies and procedur staff, individuals prov arrangement, contract	w and rehearse its ness plan with hospice nonemployee staff), with ced on carrying out the y to protect patients and nation of all emergency g. preparedness policies and icantly updated, the hospice y on the updated policies and 184(d):] (1) Training must do all of the following: nergency preparedness res to all new and existing iding services under unteers, consistent with their g, provide emergency g every 2 years. f knowledge of emergency mation of all emergency g. preparedness policies and icantly updated, the PRTF y on the updated policies and icantly updated policies and icantly updated policies and icantly updated policies and	EC	037				

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/30/2 FORM APPRO OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495386	B. WING		C 05/27/2021	
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CC	DDE	
CARRING	TON PLACE AT BOTET	OURT COMMONS		COMMONS PARKWAY LEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETI TE APPROPRIATE DATE	
E 037	<ul> <li>(ii) Provide emergence least every 2 years.</li> <li>(iii) Demonstrate staff procedures, including what to do, where to case of an emergence (iv) Maintain docume (v) If the emergency procedures are signif must conduct training procedures.</li> <li>*[For LTC Facilities a Program. The LTC fa following:</li> <li>(i) Initial training in en policies and procedure staff, individuals prov arrangement, and vol expected role.</li> <li>(ii) Provide emergence least annually.</li> <li>(iii) Maintain docume preparedness training (iv) Demonstrate staff procedures.</li> <li>*[For CORFs at §485 CORF must do all of (i) Provide initial train preparedness policies and existing staff, ind under arrangement, a with their expected ro (ii) Provide emergence least every 2 years.</li> <li>(iii) Maintain docume</li> </ul>	cy preparedness training at f knowledge of emergency g informing participants of go, and whom to contact in ry. ntation of all training. preparedness policies and ficantly updated, the PACE g on the updated policies and t §483.73(d):] (1) Training cility must do all of the mergency preparedness res to all new and existing riding services under lunteers, consistent with their cy preparedness training at ntation of all emergency g. f knowledge of emergency s and procedures to all new lividuals providing services and volunteers, consistent	E 037			

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		ND HUMAN SERVICES MEDICAID SERVICES				M APPROVE 0. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495386	B. WING		C 05/27/2021		
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CO	•		
CARRING	TON PLACE AT BOTET	OURT COMMONS	2	90 COMMONS PARKWAY			
				DALEVILLE, VA 24083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE	
E 037	Continued From page	e 10	E 037				
2007		personnel must be oriented	E 037				
		c responsibilities regarding					
		icy plan within 2 weeks of					
		ne training program must					
		the location and use of					
	alarm systems and s equipment.	ignals and firefighting					
		/ preparedness policies and					
		ficantly updated, the CORF					
		g on the updated policies and					
	procedures.						
	*[For CAHs at §485.6 The CAH must do all	625(d):] (1) Training program.					
		nergency preparedness					
	policies and procedu						
		ishing of fires, protection,					
		y, evacuation of patients,					
	cooperation with firef	ts, fire prevention, and					
	authorities, to all new						
		services under arrangement,					
	and volunteers, cons	istent with their expected					
	roles.						
		cy preparedness training at					
	least every 2 years. (iii) Maintain docume	ntation of the training.					
		f knowledge of emergency					
	procedures.						
		/ preparedness policies and					
		ficantly updated, the CAH					
	procedures.	g on the updated policies and					
	For CMHCs at 848	5.920(d):] (1) Training. The					
		initial training in emergency					
		s and procedures to all new					
	and existing staff inc	lividuals providing services					

Facility ID: VA0388

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		, <i>'</i>		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495386	B. WING				C / <b>27/2021</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CARRING	TON PLACE AT BOTETC	OURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	with their expected ro documentation of the demonstrate staff kno procedures. Thereaft emergency preparedry years. This REQUIREMENT by: Based on staff intervi documentation review that all facility staff rea Preparedness (EP) tra The facility provided E approximately 80 staff The Findings included On 5/25/21, a review staff training attendant fifteen of approximate trained. On 5/26/21 at 2:30 P. conducted via telepho Administrator. She wa following items were re 1) annual review and Whole 2) annual review and Procedures therein 3) training and testing	<ul> <li>and volunteers, consistent les, and maintain training. The CMHC must weldge of emergency ter, the CMHC must provide hess training at least every 2</li> <li>is not met as evidenced iew and facility (a, the facility failed to ensure ceived annual Emergency aning.</li> <li>EP training to only 15 out of f members.</li> <li>d:</li> <li>was conducted of the EP tee sheet. On 4/28/21, ely 80 staff members were</li> <li>M., an interview was one with the facility as informed that the not contained in the EP plan: updates of the Policies and updates of the Policies and updates mergency preparedness</li> </ul>	E	037	7		

Facility ID: VA0388

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	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		
			` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495386	B. WING		C 05/27/2021
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	
CARRINGT	ON PLACE AT BOTETO	URT COMMONS		290 COMMONS PARKWAY	
				DALEVILLE, VA 24083	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
	He did not answer ar emergency preparedr his supervisor, or wha during an emergency. loudly the questions th was overheard saying person, "They are ask wants me to answer the Surveyor on hold stated that he had relev He then continued to was asked, and not p On 5/26/21 at 1:40 P. conducted with the Oc telephone. She stated any emergency comm further stated that she responsibilities were of stated that she had not that she was aware the inside the managers' after 5:30 P.M. The Administrator stated find the documentation she had been hired not The Administrator stated approximately 80 staff training. She stated the reason why all of the stated the stated the the stated the stated the stated the treason why all of the stated the stated the stated the treason why all of the stated the stated the stated the stated the stated the stated the treason why all of the stated the treason why all of the stated	M., an interview was eceptionist via telephone. ay questions regarding ness, including the name of at his responsibilities were . He would only repeat that were asked of him. He to another unknown sing me questions. She only hem." The Receptionist put for five minutes. He then pocated to the activity room. repeat the questions that he rovide responses.	EC	937	
	of the utmost importa	nce. You can't handle an not trained. People don't			
	EP Testing Requireme	-	EC	039	

Facility ID: VA0388

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		495386	B. WING				27/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		-
CARRING	TON PLACE AT BOTETO	OURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
E 039	CFR(s): 483.73(d)(2) §416.54(d)(2), §418.7 §460.84(d)(2), §482.1 §483.475(d)(2), §482.1 §483.475(d)(2), §484.4 §485.625(d)(2), §485. §491.12(d)(2), §494.6 *[For ASCs at §416.5 "Organizations" unde §485.920, RHCs/FQF Facilities at §494.62]: (2) Testing. The [facilit to test the emergency must do all of the follo (i) Participate in a full- community-based eve (A) When a commun accessible, conduct a exercise every 2 year (B) If the [facility] natural or man-made activation of the emer exempt from engagin community-based or functional exercise for actual event. (ii) Conduct an addition years, opposite the year this section is conduct not limited to the follo (A) A second full-scal	<ul> <li>(13(d)(2), §441.184(d)(2), 5(d)(2), §483.73(d)(2), 102(d)(2), §485.68(d)(2), 727(d)(2), §485.920(d)(2), 52(d)(2).</li> <li>(4, CORFs at §485.68, OPO, r §485.727, CMHCs at ICs at §491.12, and ESRD</li> <li>(5) ty] must conduct exercises r plan annually. The [facility] owing:</li> <li>(1) escale exercise that is ery 2 years; or ity-based exercise is not facility-based functional s; or</li> <li>(2) experiences an actual emergency that requires gency plan, the [facility] is g in its next required ndividual, facility-based llowing the onset of the</li> <li>(2) on al exercise at least every 2 ear the full-scale or nder paragraph (d)(2)(i) of ted, that may include, but is wing:</li> <li>(3) exercise that is individual, facility-based</li> </ul>	E	039			

Event ID: 8P5Y11

Facility ID: VA0388

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/30/2021 FORM APPROVED //B NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		3) DATE SURVEY COMPLETED
		495386	B. WING				C 05/27/2021
NAME OF P	ROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIP CODI	E	
CARRING	TON PLACE AT BOTETO			290	COMMONS PARKWAY		
CANING	TON PEACE AT BOTER			DA	LEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	a facilitator and includ a narrated, clinically-r scenario, and a set of directed messages, of designed to challenge (iii) Analyze the [facili maintain documentati exercises, and emerg [facility's] emergency *[For Hospices at 418 (2) Testing for hospic patient's home. The exercises to test the e annually. The hospic (i) Participate in a ful community based eve (A) When a communi accessible, conduct a functional exercise eve (B) If the hospice exp man-made emergency the emergency plan, engaging in its next re community-based function onset of the emergen (ii) Conduct an additi opposite the year the exercise under parag is conducted, that ma to the following: (A) A second full-sca community-based or exercise; or (B) A mock disaster of	se or workshop that is led by des a group discussion using relevant emergency f problem statements, or prepared questions e an emergency plan. ty's] response to and ion of all drills, tabletop gency events, and revise the plan, as needed. 3.113(d):] tes that provide care in the hospice must conduct emergency plan at least the must do the following: I-scale exercise that is ery 2 years; or ty based exercise is not an individual facility based very 2 years; or ty that requires activation of the hospital is exempt from equired full scale ercise or individual hal exercise following the toy event. ional exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section by include, but is not limited the exercise that is a facility based functional	E	039			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		495386	B. WING				C 27/2021	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
CARRING	TON PLACE AT BOTETC	OURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
E 039	a facilitator and incluc a narrated, clinically-r scenario, and a set of directed messages, o designed to challenge (3) Testing for hospice care directly. The hose exercises to test the e year. The hospice m (i) Participate in an a is community-based; (A) When a communi accessible, conduct a facility-based function (B) If the hospice exp man-made emergency the emergency plan, f engaging in its next re based or facility-base following the onset of (ii) Conduct an additi may include, but is no (A) A second full-sca community-based or exercise; or (B) A mock disaster of (C) A tabletop exercis facilitator that include narrated, clinically-rel and a set of problem messages, or prepare challenge an emerger (iii) Analyze the hosp maintain documentati	les a group discussion using elevant emergency <sup>5</sup> problem statements, r prepared questions e an emergency plan. es that provide inpatient spice must conduct emergency plan twice per ust do the following: nnual full-scale exercise that or ty-based exercise is not n annual individual hal exercise; or eriences a natural or y that requires activation of the hospice is exempt from equired full-scale community d functional exercise the emergency event. onal annual exercise that ot limited to the following: le exercise that is a facility based functional drill; or se or workshop led by a s a group discussion using a evant emergency scenario, statements, directed ed questions designed to ncy plan. ice's response to and on of all drills, tabletop ency events and revise the	E	039	9			

Facility ID: VA0388

If continuation sheet Page 16 of 41

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495386	B. WING				C 27/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		-
CARRING	TON PLACE AT BOTETC	OURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
E 039	Continued From page	9 16	E	039			
	conduct exercises to twice per year. The [ do the following: (i) Participate in an a is community-based; (A) When a communi accessible, conduct a facility-based function (B) If the [PRTF, Hos actual natural or man requires activation of [facility] is exempt from required full-scale con facility-based function onset of the emergen (ii) Conduct an [i and that may include, following: (A) A second full-scale community-based or functional exercise; o (B) A mock of (C) A tabletop ex led by a facilitator and discussion, using a na emergency scenario, statements, directed to plan. (iii) Analyze the [ maintain documentati	§485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must nnual full-scale exercise that or ty-based exercise is not in annual individual, hal exercise; or pital, CAH] experiences an -made emergency that the emergency plan, the m engaging in its next mmunity based or individual, hal exercise following the cy event. additional] annual exercise or but is not limited to the le exercise that is individual, a facility-based r disaster drill; or ercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency facility's] response to and on of all drills, tabletop pency events and revise the					

Facility ID: VA0388

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPRO OMB NO. 0938-		
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		495386	B. WING		C 05/27/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
				290 COMMONS PARKWAY			
CARRING	TON PLACE AT BOTETO	JURI COMMONS		DALEVILLE, VA 24083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLE THE APPROPRIATE DATE		
E 039	Continued From page	e 17	E 03	9			
	*[For PACE at §460.8	34(d):1					
		E organization must conduct					
		emergency plan at least					
		organization must do the					
	following:						
		annual full-scale exercise that					
	is community-based;						
		ity-based exercise is not					
	accessible, conduct a						
	facility-based function						
		riences an actual natural or					
	-	cy that requires activation of					
		the PACE is exempt from equired full-scale community					
		acility-based functional					
		e onset of the emergency					
	event.	e chier of the chiergeney					
		dditional exercise every 2					
		ear the full-scale or functional					
		raph (d)(2)(i) of this section					
		y include, but is not limited to					
	the following:	-					
	(A) A second full-sca	ale exercise that is					
	•	individual, a facility based					
	functional exercise; o						
	(B) A mock disaster						
	• •	ise or workshop that is led by					
		des a group discussion,					
	-	ically-relevant emergency					
		f problem statements, or prepared questions					
		e an emergency plan.					
	(iii) Analyze the PAC						
		ion of all drills, tabletop					
		gency events and revise the					
	PACE's emergency p						
	*[For LTC Facilities a						
		+ \$ 100 70/201					

Facility ID: VA0388

If continuation sheet Page 18 of 41

		ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 12/30/2021 ORM APPROVED NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE S COMPL		
		495386	B. WING				C 05/27/2021	
NAME OF P	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
	TON PLACE AT BOTETO			290	COMMONS PARKWAY			
CARRING	TON PLACE AT BOTEIC	JURT COMMONS		DA	LEVILLE, VA 24083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
E 039	test the emergency p including unannounce emergency procedure ICF/IID] must do the f (i) Participate in an a is community-based; (A) When a communi accessible, conduct a facility-based function (B) If the [LTC facility] actual natural or man requires activation of LTC facility is exempt required a full-scale of individual, facility-bas following the onset of (ii) Conduct an additi may include, but is no (A) A second full-scale community-based or functional exercise; o (B) A mock disaster of (C) A tabletop exerci a facilitator includes a narrated, clinically-rel and a set of problem messages, or prepare challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emerge [LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/I	must conduct exercises to lan at least twice per year, ed staff drills using the es. The [LTC facility, following: nnual full-scale exercise that or ty-based exercise is not an annual individual, hal exercise. ] facility experiences an -made emergency that the emergency plan, the from engaging its next community-based or used functional exercise the emergency event. tonal annual exercise that ot limited to the following: le exercise that is an individual, facility based r drill; or se or workshop that is led by a group discussion, using a levant emergency scenario, statements, directed ed questions designed to ncy plan. facility] facility's response to entation of all drills, tabletop gency events, and revise the emergency plan, as needed. 3.475(d)]: ID must conduct exercises y plan at least twice per year.	E	039				

Facility ID: VA0388

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		ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 12/30/202 <sup>2</sup> DRM APPROVED NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495386	B. WING				C 05/27/2021	
NAME OF P	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP COD	E		
CARRING	TON PLACE AT BOTETO	OURT COMMONS			COMMONS PARKWAY LEVILLE, VA 24083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 039	is community-based; (A) When a community- accessible, conduct a facility-based function (B) If the ICF/IID exper man-made emergency the emergency plan, engaging in its next re- community-based or functional exercise for emergency event. (ii) Conduct an addition may include, but is not (A) A second full-scall community-based or functional exercise; or (B) A mock disaster or (C) A tabletop exercise a facilitator and include using a narrated, clim scenario, and a set or directed messages, or designed to challenge (iii) Analyze the ICF/I maintain documentate exercises, and emerge ICF/IID's emergency *[For HHAs at §484.1 (d)(2) Testing. The HI to test the emergency least annually. The H (i) Participate in a full community-based; or (A) When a comma	nnual full-scale exercise that or ity-based exercise is not an annual individual, hal exercise; or. eriences an actual natural or cy that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based llowing the onset of the onal annual exercise that of limited to the following: le exercise that is an individual, facility-based r frill; or se or workshop that is led by des a group discussion, ically-relevant emergency f problem statements, or prepared questions e an emergency plan. ID's response to and ion of all drills, tabletop gency events, and revise the plan, as needed. 02] HA must conduct exercises y plan at HA must do the following: -scale exercise that is	E	039				

Facility ID: VA0388

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		495386	B. WING				_ 27/2021
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CARRING	TON PLACE AT BOTETC	OURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	or man-made emerge of the emergency plate engaging in its next re community-based or if functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under parage is conducted, that limited to the following (A) A second full- community-based or a functional exercise; o (B) A mock disase (C) A tabletop ex led by a facilitator and discussion, using a na emergency scenario, statements, directed of questions designed to plan. (iii) Analyze the HHA' documentation of all of emergency plan, as na *[For OPOs at §486.3 (d)(2) Testing. The Of to test the emergency following: (i) Conduct a paper-b workshop at least and led by a facilitator and	<ul> <li>Apperiences an actual natural ency that requires activation in, the HHA is exempt from equired full-scale individual, facility based llowing the onset of the</li> <li>Appendix and the onset of the individual, facility based llowing the onset of the individual, facility based individual, facility based individual, facility-based or functional raph (d)(2)(i) of this section to may include, but is not g:</li> <li>scale exercise that is an individual, facility-based or functional raph (d)(2)(i) of this section to may include, but is not g:</li> <li>scale exercise that is an individual, facility-based or functional raph (d)(2)(i) of this section to may include, but is not g:</li> <li>scale exercise that is an individual, facility-based or further drill; or</li> <li>ercise or workshop that is a includes a group arrated, clinically-relevant and a set of problem messages, or prepared or challenge an emergency or challenge an emergency is response to and maintain drills, tabletop exercises, and hor revise the HHA's eeded.</li> <li>ac60]</li> <li>PO must conduct exercises or plan. The OPO must do the ased, tabletop exercise or invally. A tabletop exercise is d includes a group arrated, clinically relevant</li> </ul>	E	039			

Facility ID: VA0388

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 12/30/20 DRM APPROVI NO. 0938-03	
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495386	B. WING _			C 05/27/2021		
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	·		
CARRING	TON PLACE AT BOTETO	OURT COMMONS						
				DA	ALEVILLE, VA 24083	FOTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
E 039	Continued From page	a 21	EO	120				
E 000		messages, or prepared		139				
		o challenge an emergency						
	• •	eriences an actual natural or						
		cy that requires activation of						
		the OPO is exempt from equired testing exercise						
		the emergency event.						
		s response to and maintain						
		tabletop exercises, and nd revise the [RNHCI's and						
	OPO's] emergency pl	=						
	*[ RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:							
	least annually. A table	ased, tabletop exercise at etop exercise is a group acilitator, using a narrated,						
		ergency scenario, and a set						
		s, directed messages, or						
	emergency plan.	esigned to challenge an						
	(ii) Analyze the RNH0							
		ion of all tabletop exercises,						
	and emergency even emergency plan, as r	ts, and revise the RNHCI's						
		is not met as evidenced						
	by:							
	Based on staff interv							
	documentation review participate in Emerge	w, the facility falled to ency Preparedness (EP) full						
	scale exercises.							
	The facility staff failed exercise.	to participate in a full scale						
	The Findings include	d:						

Facility ID: VA0388

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/30/2021 RM APPROVED NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495386	B. WING				C )5/27/2021	
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
CARRING	TON PLACE AT BOTETC	OURT COMMONS			00 COMMONS PARKWAY ALEVILLE, VA 24083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
E 039	Continued From page	22	E	039				
F 000	documentation. There facility had collaborate participated in a full so there was no evidence coordinated with outs a full scale exercise. The Administrator sta find the documentation she had been hired no The Administrator sta the reason why the far a full scale exercise, of arrangements to do so INITIAL COMMENTS	ide EP agencies to schedule ted that she was unable to on. She further stated that ear the beginning of 2021. ted that she was unaware of ucility had not participated in or made specific so.	F	000				
	survey was conducted Corrections are require CFR Part 483 Federa requirements. The Li survey/report will follo The census in this 90 at the time of the surv consisted of 19 current	fe Safety Code ow. certified bed facility was 82 vey. The survey sample nt Resident reviews and 3						
F 641 SS=D	closed record reviews Accuracy of Assessm CFR(s): 483.20(g)		F	641				
	resident's status. This REQUIREMENT by:	of Assessments. t accurately reflect the is not met as evidenced iew and clinical record						

Event ID: 8P5Y11

Facility ID: VA0388

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED C
		495386	B. WING				0 /27/2021
NAME OF P	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CARRING	TON PLACE AT BOTETC	OURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
F 641	MDS (minimum data the resident's status f Resident #61. The findings include: For Resident #61, fac resident's most recen quarterly MDS assess Resident #61's diagne which included, not lin Disease, Unspecified Disturbance, Schizoa Type, Major Depressi Moderate, Agoraphot Chronic Pain Syndror The most recent quar an ARD (assessment assigned the resident mental status) score of Cognitive Patterns. In Swallowing/Nutritiona most recent weight in with a "-". Resident # unknown" for a weigh month or loss of 10% and "no or unknown" more in the last monti last 6 months. A review of Resident revealed a document obtained on 4/15/21.	ff failed to accurately code a set) assessment to reflect for 1 of 22 residents, cor 1 of 22 resident diagnoses, cor 1 of 22 resident with cor 23/21 set of 23/21 cor 23/21	F	641			

Facility ID: VA0388

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		LETED
		495386	B. WING				C 27/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
CARRING	TON PLACE AT BOTETC	OURT COMMONS			90 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	spoke with the DON ( stated the MDS has b weight of 187.3. On 5/26/21 at 5:00 pr administrative team in DON, human resource surveyor discussed th MDS not being accur resident's weight. No further information presented to the surv conference on 5/27/2 ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on resident in clinical record review, ensure that residents out activities of daily I care and services to r for 7 of 22 residents, 62, 64 and 11. The findings included 1. For Resident #12, f	imately 3:00 pm, surveyor director of nursing) who been corrected with the in during a meeting with the ncluding the administrator, es, and the regional nurse, he concern of Resident #61's rately coded for the in regarding this issue was ey team prior to the exit 1. or Dependent Residents ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced terview, staff interview, and the facility staff failed to who were unable to carry iving received the necessary maintain personal hygiene Residents #12, 19, 32, 45, : the facility failed to complete l2's toenails were observed		641			
F 677	On 5/26/21 at approx spoke with the DON ( stated the MDS has b weight of 187.3. On 5/26/21 at 5:00 pr administrative team in DON, human resourc surveyor discussed th MDS not being accur resident's weight. No further information presented to the surv conference on 5/27/2 ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on resident in clinical record review, ensure that residents out activities of daily I care and services to r for 7 of 22 residents, 62, 64 and 11. The findings included 1. For Resident #12, f nail care. Resident #12, f	imately 3:00 pm, surveyor director of nursing) who been corrected with the in during a meeting with the ncluding the administrator, es, and the regional nurse, he concern of Resident #61's rately coded for the in regarding this issue was ey team prior to the exit 1. or Dependent Residents ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced terview, staff interview, and the facility staff failed to who were unable to carry iving received the necessary maintain personal hygiene Residents #12, 19, 32, 45, : the facility failed to complete l2's toenails were observed					

Facility ID: VA0388

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495386	B. WING				C 27/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARRING	TON PLACE AT BOTETC	OURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	multiple myeloma, ma and Parkinson's disea Section C (cognitive p significant change in a set assessment with a reference date of 05/0 brief interview for men of 8 out of a possible (functional status) wa hygiene to indicate th extensive assistance Resident #12's (CCP) included the problem to weakness on hosp anticipated. Approach time to complete (ADI 05/26/21 4:35 p.m., to and thick in appearan nursing assistant that during this observatio in today. 05/26/21 5:02 p.m., e administrator, (DON) regional nurse consul resource personnel # regarding the residen with these staff. The I responsibility of the C administrator stated ti residents nails and ha	sheet included the diagnosis, alignant neoplasm of colon, ase. batterns) of the residents status (MDS) minimum data an (ARD) assessment 01/2021 included a (BIMS) ntal status summary score 15 points. Section G s coded (3/2) for personal e resident required of one person for this task. comprehensive care plan area self-care deficit related ice services with decline hes included, allow extra Ls) activities of daily living. benails observed to be long ice. The (CNA) certified caccompanied the surveyor in stated hospice had been and of the day meeting with director of nursing, (RNC) itant and (HR) human 1 and #2. The issue ts nail care was addressed DON stated it was the cNAs to cut fingernails. The	F	677			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		495386	B. WING			05	C / <b>27/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARRING	TON PLACE AT BOTETO	DURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 677	Continued From page	e 26	F	677	,		
	complete nail care. R	the facility staff failed to resident #19's fingernails and ed to be long and jagged in					
		sheet included the diagnosis iple sclerosis, and vascular					
	a BIMS status summa possible 15 points. So was coded (4/3) total	dents quarterly MDS ARD of 02/19/2021 included ary score of 0 out of a ection G (functional status) dependent on two persons dressing, and bathing.					
	self-care deficit relate dementia, dependent	ncluded the problem area ed to multiple sclerosis, t on staff to anticipate and ches included keep nails					
	Resident #19's feet w	) licensed practical nurse #2. vere noted to be dry and ls and fingernails were					
	administrator, DON, F and #2. The issue reg care was reviewed. T responsibility of the C administrator stated t	end of the day meeting with RNC, and HR personnel #1 garding the residents nail The DON stated it was the CNAs to cut fingernails. The hey would look at the ave them taken care of.					
		n regarding this issue was y team prior to the exit					

Facility ID: VA0388

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	-	D HUMAN SERVICES //EDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFI AND PLAN OF CORRI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION		LETED
		495386	B. WING _				C 27/2021
NAME OF PROVIDE	R OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CARRINGTON P	PLACE AT BOTETO	URT COMMONS			0 COMMONS PARKWAY ALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Confe 3. Fo nail o were Resi traur disea Sect asse a BIN Sect resid perso Resi self-( hanc them 05/20 long Hosp 05/20 long Hosp 05/20 long Hosp 05/20 long Hosp 05/20 long Hosp 05/20 long Hosp 05/20 No fu provi	care. Resident #3 e observed to long dent #32's face sl matic subdural he ase, and unspecif ion C of the residu- ssment with an A MS score of 9 out ion G was coded dent required exte on for this task. dent #32's CCP in care deficit. Appro- ds on assist for se in to do as much for 6/2021 4:38 p.m., and toenails long bice in today to se 6/21 5:02 p.m., er inistrator, DON, R se staff were mad- rding the resident the responsibility ernails. The admin at the residents n of. urther information	he facility failed to complete 2's fingernails and toenails and jagged in appearance. neet included the diagnosis, morrhage, Parkinson's	F 6	377			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495386	B. WING				C 27/2021
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		-
CARRING	TON PLACE AT BOTETC	OURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 677	<ul> <li>4. For Resident #45, inail care. Resident #45, inail care. Resident #45, inail care. Resident #4 were observed to long Resident #45's face is cerebral infarction, dy generalized anxiety d Section C of Residen MDS assessment with included a BIMS scorpoints. Section G wa assistance of one per Resident #45's CCP i self-care deficit relate related to past (CVA) and unable to complet Approaches included trimmed.</li> <li>05/26/21 3:12 p.m., C #45's fingernails and CNA #1. The toenails to be long and jagged the nails were noted t resident's feet. Reside have any clippers.</li> <li>05/26/21 5:02 p.m., e administrator, DON, F #2. The issues regard was reviewed. The D responsibility of the C administrator stated ti </li></ul>	the facility failed to complete IS's fingernails and toenails g and jagged in appearance. Theet included the diagnosis, rsphagia, type 2 diabetes, isorder. t #45's significant change h an ARD of 03/12/2021 e of 12 out of a possible 15 s coded (2/2) for limited rson for personal hygiene. ded to indicate the resident oth sides in the lower Included the problem area d to impaired mobility cerebrovascular accident te self-care tasks. keep nails clean and Observation of Resident toenails completed with on both feet were observed I in appearance. Some of to be curved in toward the ent #45 stated they did not Ind of the day meeting with RNC, HR personnel #1 and ding the residents nail care ON stated it was the "NAs to cut fingernails. The	F	67	7		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
		495386	B. WING	NG.			C / <b>27/2021</b>	
NAME OF P	ROVIDER OR SUPPLIER		-	5	STREET ADDRESS, CITY, STATE, ZIP CODE	05/	2112021	
					290 COMMONS PARKWAY			
CARRING	TON PLACE AT BOTETO	DURI COMMONS		1	DALEVILLE, VA 24083	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Continued From page	29	F	677	7			
	Resident #45 stated t toenails. Resident #4 blankets and they we surveyor check their f made per resident red No further information provided to the surve conference.	n regarding this issue was y team prior to the exit the facility failed to complete 52's fingernails were						
		<b>2</b>						
	a BIMS score of 13 o Section G was coded	ARD of 04/22/2021 included ut of a possible 15 points.						
	self-care deficit and is	cluded the problems area s at risk for behaviors related polar, may self isolate and						
		, observed fingernails to be fused to let the surveyor						
		nd of the day meeting with RNC, and HR personnel #1						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495386	B. WING				C 27/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		-
CARRING	TON PLACE AT BOTETC	OURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 677	<ul> <li>and #2. The issue regcare was reviewed. Tresponsibility of the Cadministrator stated thresidents nails and har No further information provided to the survey conference.</li> <li>6. For Resident #64, complete nail care. R toenails were observe under in appearance.</li> <li>Resident #64's face s Parkinson's disease, hyperplasia, vascular lewy bodies, and trau without loss of consci Section C of the residation of the survey conformer equired externation of the section G was coded resident required externation of the survey person for personal h Resident #64's CCP in impaired ability to bat independently related deficit. Approaches in trimmed.</li> <li>05/26/2021 4:59 p.m. long with debris preset</li> </ul>	yarding the residents nail he DON stated it was the NAs to cut fingernails. The hey would look at the ave them taken care of. In regarding this issue was y team prior to the exit the facility staff failed to esident #64's fingernails and ed to be long and curved wheet included the diagnosis, benign prostatic dementia, dementia with matic subdural hemorrhage ousness. lent's quarterly MDS NRD of 04/26/2021 included t of a possible 15 points. (3/2) to indicate the ensive assistance of one	F	677			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/30/2021 // APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	
		495386	B. WING	_			C 27/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
				2	290 COMMONS PARKWAY		
CARRING	TON PLACE AT BOTETO	DURI COMMONS		C	DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 677	05/26/21 5:02 p.m., e administrator, DON, F and #2. The issues re- care was reviewed. T responsibility of the C administrator stated ti residents nails and ha No further information provided to the survey conference. 7. For Resident #11, provide assistance wi resident's preference Resident #11's diagnow which included, but no Spondylolisthesis Lur Disorder, Hereditary I Neuropathy, Muscle V Epilepsy Unspecified Status Epilepticus. The most recent quar set) with an ARD (ass 4/22/21 assigned the interview for mental s in section C, Cognitiv was coded as being t On 5/26/21 at 9:19 ar Resident #11 who stat their shower on Mon enough staff. Reside happens often on Mo 8:58 am, surveyor ag concerning their show receive showers two	nd of the day meeting with RNC, and HR personnel #1 egarding the residents nail he DON stated it was the NAs to cut fingernails. The hey would look at the ave them taken care of. In regarding this issue was y team prior to the exit the facility staff failed to th showers per the of twice weekly. Dosis list indicated diagnoses, ot limited to nbar Region, Bipolar II	F	677			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		495386	B. WING _				C 27/2021		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE				
CARRING	TON PLACE AT BOTETC	OURT COMMONS			0 COMMONS PARKWAY ALEVILLE, VA 24083	OF CORRECTION (X5)			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI> TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 677	like a shower twice a Resident #11 stated a self into the bathroom "bird bath". Surveyor reviewed Re History report for ADL for showers which ind showers/bed baths w from 4/01/21 through dates: 4/01/21, 4/15/ 5/10/21, 5/17/21, and administrator provide Body Check/Work-up and stated the form w given that day. Resident #11's currer approach stating in pa shower or bath, per (f weekly". On 5/27/21 at 1:58 pr administrator and reg discussed the concer assisted with showers preference.	d Resident #11 if they would week and they stated "yes". sometimes (he/she) takes a and gives (his/her) self a esident #11's Point of Care is (activities of daily living) cluded documentation that ere provided seven times 5/26/21 on the following 21, 4/26/21, 4/29/21, 5/20/212. The d a form entitled "SHARE Quality Tool" dated 5/03/21 vas completed with a shower at care plan includes an art "assist (him/her) with a his/her) preference, twice in during a meeting with the ional nurse, surveyor in of Resident #11 not being is twice weekly per their	F6	577					
		are ndamental principle that nt and care provided to							

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/30/2021 RM APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495386	B. WING		0	C 5/27/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO		
CARRING	TON PLACE AT BOTETO	OURT COMMONS		290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 684	assessment of a residents received accordance with profe- practice, the compret- care plan, and the rest This REQUIREMENT by: Based on staff interver review, the facility star residents receive treat accordance with the operson-centered care Residents #31 and # The findings included 1. For Resident #31, physician's orders for Acidophilus (a probio skeletal muscle relax certain types of spast benzodiazepine used control muscle spasm Gabapentin (an antic seizures, restless leg nerve pain), and Sime medication). Resident #31's diagn which included, but lin Atrophy not Elsewher Unspecified Injury at Cervical Spinal Cord, Generalized Anxiety I Depressive Disorder The most recent quar	ed on the comprehensive dent, the facility must ensure a treatment and care in essional standards of hensive person-centered sidents' choices. T is not met as evidenced iew and clinical record off failed to ensure the atment and care in comprehensive a plan for 2 of 22 residents, 19. It: facility staff failed to follow the administration of tic supplement), Baclofen (a ant used to treat pain and ticity), Diazepam (a I to relieve anxiety and hs and spasticity), onvulsant used to control syndrome, and relieve ethicone (an anti-gas osis list indicated diagnoses, mited to Muscle Wasting and re Classified Other Site, Unspecified Level of Functional Quadriplegia, Disorder, and Major	F 68-	4		

Facility ID: VA0388

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/30/2021 MAPPROVED ). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495386	B. WING				C 27/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CARRING	TON PLACE AT BOTETO	URT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	4/27/21 assigned the interview for mental s in section C, Cognitive Resident #31 has the orders: Acidophilus (i capsule 1 oral twice a 1.5 tablets by mouth f quadriplegia, Diazepa times daily, Gabapent mouth three times da Mi-Acid Gas Relief (S mg chewable tablet b A review of Resident 1 (medication administr following medication a Acidophilus 5/13/21 1 pm; Baclofen 5/13/21 1 pm; 5/14/21 2:00pm, Gabapentin 5/13/21 1 and 5/20/21 10:00 pm 10:00 pm and 5/20/21 Resident #31's currer includes the approach administer medication On 5/26/21 at 4:36 pm DON (director of nurs omissions and the DO explanation".	resident a BIMS (brief tatus) score of 15 out of 15 e patterns. following active physician lactobacillus acidophilus) day, Baclofen tablet 20 mg our times daily for m 5 mg by mouth three tin 300 mg 1 capsule by lly for quadriplegia, and imethicone) [OTC] tablet 80 y mouth at bedtime. #31's May 2021 MAR ation record) revealed the administration omissions: 0:00 pm and 5/20/21 10:00 10:00 pm, 5/14/21 2:00 pm, 5 Diazepam 5/13/21 10:00 and 5/20/21 10:00 pm; 0:00 pm, 5/14/21 2:00 pm at care plan addressing pain n dated 8/16/19 to as as ordered. n surveyor spoke with the ing) concerning the MAR DN stated "I don't have an an during a meeting with the onsisting of the numan resources, and the rveyor discussed the	F	584			

Facility ID: VA0388

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	-	ID HUMAN SERVICES				FOR	M APPROVED
STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
			A. BUILDI	ING			C
		495386	B. WING			05/	/27/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CARRING	TON PLACE AT BOTETC	OURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	administration omissis 5/20/21. Surveyor spoke with t 5/27/21 at 1:22 pm wi stated they did give th it is possible that they button on the comput No further information presented to the surv conference on 5/28/2 2. For Resident #19, administer the physic Levothyroxine 75 mcg available in the stat b medication room. Resident #19's face s hypothyroidism, multi dementia. Section C (cognitive p quarterly (MDS) minir with an (ARD) assess 02/19/2021 included a mental status summa possible 15 points. Resident 19's (EHR) included a physician of mcg before breakfast A review of Resident medication administra	the regional nurse on ho stated the agency nurse he 2:00 pm medications and may have not hit the save er. In regarding this issue was ey team prior to the exit 1. the facility staff failed to ian ordered medication g. This medication was ox located in the facility theet included the diagnosis ple sclerosis, and vascular the facility of the residents mum data set assessment sment reference date of a (BIMS) brief interview for rry score of 0 out of a electronic health record order for Levothyroxine 75 . Date of order 02/02/2021. #19's (EMARs) electronic ation records revealed that 0 a.m. the nursing staff ministered: Drug/Item	F	684			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/30/2021 1 APPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		ì í			(X3) DATE SURVEY COMPLETED		
4953		495386	B. WING		C 05/27/2021		
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
	TON PLACE AT BOTETO			2	290 COMMONS PARKWAY		
CANING	ION FLACE AI BOILIO			0	DALEVILLE, VA 24083		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	2 36	F 684				
F 756 SS=D	<ul> <li>05/26/2021 2:18 p.m., the surveyor checked the stat box with (LPN) licensed practical nurse #1. Per the label attached to this stat box, this box contained 4 tablets of Levothyroxine 25 mcg. Indicating the medication would have been available for administration.</li> <li>05/26/2021 5:02 p.m., during an end of the day meeting with the administrator, (DON) director of nursing, regional nurse consultant, and (HR) human resource employees #1 and #2 these staff were made aware of the issue regarding Resident #19's Levothyroxine not being administered on 05/14/2021. The DON stated the nursing staff should have contacted the pharmacy and obtained authorization to pull the medication.</li> <li>No further information regarding this issue was provided to the surveyor prior to the exit conference.</li> <li>Drug Regimen Review, Report Irregular, Act On</li> </ul>			756			
	and these reports mu (i) Irregularities includ	etor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph					

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		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 12/30/2021 FORM APPROVED B NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
495386			B. WING				C 05/27/2021		
NAME OF P	ROVIDER OR SUPPLIER	1			STREET ADDRESS, CITY, STATE, ZIP CODE	•			
CARRING	TON PLACE AT BOTETO	OURT COMMONS			290 COMMONS PARKWAY DALEVILLE, VA 24083				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID		PROVIDER'S PLAN OF CORF		(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		COMPLETION DATE		
F 756	Continued From page	e 37	F	756	3				
		an unnecessary drug.		100					
		noted by the pharmacist							
		ist be documented on a							
	separate, written repo								
		nd the facility's medical							
	director and director								
	minimum, the resider and the irregularity th								
	(iii) The attending phy								
	resident's medical record that the identified								
	irregularity has been	reviewed and what, if any,							
		n to address it. If there is to							
		medication, the attending							
	physician should doc the resident's medica	ument his or her rationale in							
	the resident's medica	a record.							
	§483.45(c)(5) The fac	cility must develop and							
		procedures for the monthly							
		that include, but are not							
		s for the different steps in							
		s the pharmacist must take ifies an irregularity that							
		n to protect the resident.							
		is not met as evidenced							
	by:								
		view and clinical record							
	review, the facility sta recommendations we	aff failed to ensure pharmacy							
		facility and failed to ensure							
	the physician followe	•							
	recommendations for								
	Residents #45 and 3	1.							
	The findings included	l:							
		the contracting pharmacist							
		macy recommendation to the							
	physician/facility and failed to ensure the physician followed up on the recommendation.								
	physician tollowed up								

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
495386			B. WING			C 05/27/2021		
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1		
	TON PLACE AT BOTETO			:	290 COMMONS PARKWAY			
	TONT LAGE AT BOTER			I	DALEVILLE, VA 24083			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG				(X5) COMPLETION DATE	
F 756	Continued From page	≥ 38	F	756	3			
		wheet included the diagnosis, vsphagia, type 2 diabetes, ety disorder.						
	Section C (cognitive patterns) of Resident #45's significant change (MDS) minimum data set assessment with an (ARD) assessment reference date of 03/12/2021 included a (BIMS) brief interview for mental status score of 12 out of a possible 15 points.							
		cord review, the surveyor a pharmacy review for						
	the pharmacist had fa	r with a copy of a ed 02/04/2021 and stated						
	surveyor with a copy indicated the physicia recommendation toda this form do not crush	in had reviewed the ay. The physician wrote on						
	provided to the survey conference. 2. For Resident #31, report the February 2 the attending physicia director, and the DOM	l (director of nursing).						
		osis list indicated diagnoses, mited to Muscle Wasting and						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391			
		, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
495386		B. WING			C 05/27/2021					
NAME OF PI	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>				
	TON PLACE AT BOTETO			2	290 COMMONS PARKWAY					
OANINO	TONT LAGE AT BOTER			DALEVILLE, VA 24083						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE			
F 756	Unspecified Injury at Cervical Spinal Cord, Generalized Anxiety I Depressive Disorder The most recent quar set) with an ARD (ass 4/27/21 assigned the interview for mental s in section C, Cognitiv Upon review of Resid 5/26/21, surveyor was February 2021 drug r the pharmacist. On 5/27/21 at 10:54 a DON who stated they pharmacist and they drug regimen review facility. DON stated t the recommendations DON provided survey February 2021 drug r #31 entitled "Note To Physician/Prescriber" "Please evaluate the every morning to see CMS guidelines requi psychoactive medicat lowest effective dose select one of the follo the following:, 2) Con is stable and previous failed, 3) A reduction as patient is easily de dated 2/05/21 and effective dose	e Classified Other Site, Unspecified Level of Functional Quadriplegia, Disorder, and Major Recurrent Mild. terly MDS (minimum data sessment reference date) of resident a BIMS (brief tatus) score of 15 out of 15 e patterns. ent #31's clinical record on s unable to locate the egimen review completed by am, surveyor spoke with the thave just spoken with the did not send the February recommendations to the he pharmacist is sending a now. At 11:22 am, the for with a copy of the egimen review for Resident Attending with the recommendation of order for fluoxetine 20 mg if a reduction can be tried. re a periodic review of all tion orders to see if the is being used. Please wing: 1) Reduce dose to tinue current dose as patient a attempts to reduce have attempt is contraindicated istabilized". The review is actronically signed by the	F	756						
F 756	Atrophy not Elsewher Unspecified Injury at Cervical Spinal Cord, Generalized Anxiety I Depressive Disorder The most recent quar set) with an ARD (ass 4/27/21 assigned the interview for mental s in section C, Cognitiv Upon review of Resid 5/26/21, surveyor was February 2021 drug r the pharmacist. On 5/27/21 at 10:54 a DON who stated they pharmacist and they drug regimen review of facility. DON stated t the recommendations DON provided survey February 2021 drug r #31 entitled "Note To Physician/Prescriber" "Please evaluate the every morning to see CMS guidelines requi psychoactive medicat lowest effective dose select one of the follo the following:, 2) Com is stable and previous failed, 3) A reduction as patient is easily de	e Classified Other Site, Unspecified Level of Functional Quadriplegia, Disorder, and Major Recurrent Mild. terly MDS (minimum data sessment reference date) of resident a BIMS (brief tatus) score of 15 out of 15 e patterns. ent #31's clinical record on s unable to locate the egimen review completed by am, surveyor spoke with the thave just spoken with the did not send the February recommendations to the he pharmacist is sending a now. At 11:22 am, the for with a copy of the egimen review for Resident Attending with the recommendation of order for fluoxetine 20 mg if a reduction can be tried. re a periodic review of all tion orders to see if the is being used. Please wing: 1) Reduce dose to tinue current dose as patient a attempts to reduce have attempt is contraindicated istabilized". The review is actronically signed by the	F	756						

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CENTERS FOR MEDICARE & MEDICARE			ID HUMAN SERVICES				FORM	APPROVED	
495386         B. WING         06/27/2021           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         290 COMMONS PARKWAY DALEVILLE, VA 24083           WAIL ID PRETAX         SUMMARY STATEMENT OF DEFICIENCIES (EACH ODRECHOR WAY DE ISC: IDENTIFYING INFORMATION)         ID PRETAX         PRETAX         COMPLETAON         CompLetaon         ComPLETAON           F 756         Continued From page 40         F 756	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						COMPLETED		
CARRINGTON PLACE AT BOTETOURT COMMONS     290 COMMONS PARKWAY DALEVILLE, VA 24083       V(4) 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 CORRECTIVE ACTION SHOLD BE (CACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     0051 DATE       F 756     Continued From page 40     F 756       On 5/27/21 at 11:26 am, in the presence of the survey team, the regional nurse notified the onsite NP (nurse practitioner) that the facility had just received the February drug regimen reviews from the pharmacy. The NP was immediately given Resident #31'S February 2021 drug regimen review to address. At approximately 11:45 am, surveyor received a copy Resident #31's "Note To Attending Physician/Prescriber" completed by the pharmaciston 2/05/21 with the statement "3) A reduction attempt is contraindicated as patient is easily destabilized" checked and the form signed by the NP and dated 5/27/21.     On 5/27/21 at 1:58 pm, surveyor notified the administrator and regional nurse of the concern of Resident #31's February 2021 drug regimen review not being received by the facility until today.     No further information regarding this issue was presented to the survey team prior to the exit	495386			B. WING					
CARRINGTON PLACE AT BOTETOURT COMMONS         DALEVILLE, VA 24083           V(A) ID PRETX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WISTERMENT OF DEFICIENCIES) REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PRETX TAG         PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         0/93 COMPLETION DATE           F 756         Continued From page 40         F 756           On 5/27/21 at 11:26 am, in the presence of the survey team, the regional nurse notified the onsite NP (nurse practitioner) that the facility had just received the February drug regimen reviews from the pharmacy. The NP was immediately given Resident #31's February 2021 drug regimen review to address. At approximately 11:45 am, surveyor received a copy Resident #31's "Note To Attending Physician/Prescriber" completed by the pharmacist on 2/05/21 with the statement" 3) A reduction attempt is contraindicated as patient is easily destabilized" checked and the form signed by the NP and dated 5/27/21.         On 5/27/21 at 1:58 pm, surveyor notified the administrator and regional nurse of the concern of Resident #31's February 2021 drug regimen review not being received by the facility until today.         No further information regarding this issue was presented to the survey team prior to the exit	NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
PREFIX TAG       (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY)       COMPLETION IDATE         F 756       Continued From page 40       F 756         On 5/27/21 at 11:26 am, in the presence of the survey team, the regional nurse notified the onsite NP (nurse practitioner) that the facility had just received the February drug regimen reviews from the pharmacy. The NP was immediately given Resident #31's February 2021 drug regimen review to address. At approximately 11:45 am, surveyor received a copy Resident #31's "Note To Attending Physician/Prescriber" completed by the pharmacist on 2/05/21 with the statement "3) A reduction attempt is contraindicated as patient is easily destabilized" checked and the form signed by the NP and dated 5/27/21.       On 5/27/21 at 1:58 pm, surveyor notified the administrator and regional nurse of the concern of Resident #31's February 2021 drug regimen review not being received by the facility until today.       No further information regarding this issue was presented to the survey team prior to the exit	CARRING	TON PLACE AT BOTETC	OURT COMMONS						
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	F 756	<ul> <li>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</li> <li>Continued From page 40</li> <li>On 5/27/21 at 11:26 am, in the presence of the survey team, the regional nurse notified the onsite NP (nurse practitioner) that the facility had just received the February drug regimen reviews from the pharmacy. The NP was immediately given Resident #31's February 2021 drug regimen review to address. At approximately 11:45 am, surveyor received a copy Resident #31's "Note To Attending Physician/Prescriber" completed by the pharmacist on 2/05/21 with the statement "3) A reduction attempt is contraindicated as patient is easily destabilized" checked and the form signed by the NP and dated 5/27/21.</li> <li>On 5/27/21 at 1:58 pm, surveyor notified the administrator and regional nurse of the concern of Resident #31's February 2021 drug regimen review not being received by the facility until today.</li> <li>No further information regarding this issue was presented to the survey team prior to the exit</li> </ul>		F	756				

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