STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. BUILDING _____ B. WING _____	C 05/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/25/21 through 5/27/21. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/25/2021

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E 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure that the Emergency Preparedness (EP) plan was reviewed and updated annually. The facility plan did not document the changes that occurred after 10/22/18. This included changes in the resident population, a new Administrator, the Resident and Responsible Party Letter regarding EP review, the Eastern Region Emergency Contact List, and the Memorandum of Understanding (MOU) with a Participating Facility. The Findings included: On 5/25/21, a review was conducted of the Emergency Preparedness Plan. Since the revision on 10/22/18, there was no evidence of a subsequent review and revision. The letter sent to Residents and Responsible Parties was dated 8/3/18. The Memorandum of Understanding with	E 004		

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E 004	Continued From page 2 the Participating Facility was dated 3/16/18. The Eastern Region Emergency Contact List was dated 3/22/19. The Administrator stated that she was unable to find the documentation. She further stated that she had been hired near the beginning of 2021. She was unable to state or identify documentation of any updates to the plan based on the resident population, Eastern Region Emergency Contacts, Family Notification, or the Participating Facility MOU.	E 004		
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 013		

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E 013	Continued From page 3 be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility	E 013		

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E 013	Continued From page 4 documentation review, the facility staff failed to ensure that the Emergency Preparedness (EP) Policies and Procedures were reviewed and updated annually. The facility staff failed to review and update the Emergency Preparedness (EP) Policies and Procedures. The Findings included: On 5/25/21, a review was conducted of the EP Policies and procedures. Since the revision dated 10/22/18, there was no evidence of a subsequent review and revision. The Administrator stated that she was unable to find the documentation. She further stated that she had been hired near the beginning of 2021. She was unable to state or identify documentation of updated policies and procedures.	E 013		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility]	E 036		

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E 036	Continued From page 5	E 036		

must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must

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E 036	Continued From page 6 develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure that the Emergency Preparedness (EP) Training and Testing Program had been reviewed and updated annually. The facility staff failed to review and update the Emergency Preparedness (EP) Training and Testing Program. The Findings included: On 5/25/21, a review was conducted of the EP Training and Testing Program. Subsequent to the revision dated 10/22/18, there was no evidence of an annual review and revision. The Administrator stated that she was unable to find the documentation. She further stated that she had been hired near the beginning of 2021. She was unable to state or identify documentation of updated training and testing.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1),	E 037		

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E 037	Continued From page 7 §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years.	E 037		

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(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.

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E 037	Continued From page 9 (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 10	E 037		

procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services

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E 037	Continued From page 11 under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility failed to ensure that all facility staff received annual Emergency Preparedness (EP) training. The facility provided EP training to only 15 out of approximately 80 staff members. The Findings included: On 5/25/21, a review was conducted of the EP staff training attendance sheet. On 4/28/21, fifteen of approximately 80 staff members were trained. On 5/26/21 at 2:30 P.M., an interview was conducted via telephone with the facility Administrator. She was informed that the following items were not contained in the EP plan: 1) annual review and updates of the plan as a whole 2) annual review and updates of the Policies and Procedures therein 3) training and testing review and updates 4) initial and annual emergency preparedness training 5) annual tabletop and full scale exercises	E 037		

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E 037	Continued From page 12 On 5/26/21 at 1:15 P.M., an interview was conducted with the Receptionist via telephone. He did not answer any questions regarding emergency preparedness, including the name of his supervisor, or what his responsibilities were during an emergency. He would only repeat loudly the questions that were asked of him. He was overheard saying to another unknown person, "They are asking me questions. She only wants me to answer them." The Receptionist put the Surveyor on hold for five minutes. He then stated that he had relocated to the activity room. He then continued to repeat the questions that he was asked, and not provide responses. . On 5/26/21 at 1:40 P.M., an interview was conducted with the Occupational Therapist via telephone. She stated that she was not aware of any emergency communication equipment. She further stated that she was not told what her responsibilities were during an emergency. She stated that she had not received EP training, but that she was aware that the EP manual was kept inside the managers' office, which was locked after 5:30 P.M. The Administrator stated that she was unable to find the documentation. She further stated that she had been hired near the beginning of 2021. The Administrator stated that the facility had approximately 80 staff members at the time of the training. She stated that she was unaware of the reason why all of the staff members had not received annual training. She stated, "Training is of the utmost importance. You can't handle an emergency if you are not trained. People don't remember if you don't practice."	E 037		
E 039 SS=C	EP Testing Requirements	E 039		

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E 039	Continued From page 13 CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 14 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

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a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

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E 039	Continued From page 16 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.	E 039		

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E 039	Continued From page 17 *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):]	E 039		

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E 039	Continued From page 18 (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:	E 039		

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E 039	Continued From page 19 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years;	E 039		

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or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]

(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem

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statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.
(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

*[RNCHIs at §403.748]:
(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:
(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility documentation review, the facility failed to participate in Emergency Preparedness (EP) full scale exercises.

The facility staff failed to participate in a full scale exercise.

The Findings included:

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E 039	Continued From page 22 On 5/25/21, a review was conducted of the EP documentation. There was no evidence that the facility had collaborated with other agencies and participated in a full scale exercise. In addition, there was no evidence that the facility had coordinated with outside EP agencies to schedule a full scale exercise. The Administrator stated that she was unable to find the documentation. She further stated that she had been hired near the beginning of 2021. The Administrator stated that she was unaware of the reason why the facility had not participated in a full scale exercise, or made specific arrangements to do so.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/25/21 through 5/27/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 82 at the time of the survey. The survey sample consisted of 19 current Resident reviews and 3 closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 641		

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review, the facility staff failed to accurately code a MDS (minimum data set) assessment to reflect the resident's status for 1 of 22 residents, Resident #61.

The findings include:

For Resident #61, facility staff failed to code the resident's most recent weight on the 4/23/21 quarterly MDS assessment.

Resident #61's diagnosis list indicated diagnoses, which included, not limited to Parkinson's Disease, Unspecified Dementia with Behavioral Disturbance, Schizoaffective Disorder Bipolar Type, Major Depressive Disorder Recurrent Moderate, Agoraphobia with Panic Disorder, and Chronic Pain Syndrome.

The most recent quarterly MDS assessment with an ARD (assessment reference date) of 4/23/21 assigned the resident a BIMS (brief interview of mental status) score of 14 out of 15 in section C, Cognitive Patterns. In section K, Swallowing/Nutritional Status, Resident #61's most recent weight in the last 30 days was coded with a "-". Resident #61 was also coded as "no or unknown" for a weight loss 5% or more in the last month or loss of 10% or more in last 6 months and "no or unknown" for a weight gain of 5% or more in the last month or gain of 10% or more in last 6 months.

A review of Resident #61's clinical record revealed a documented weight of 187.3 lbs. was obtained on 4/15/21. On 11/06/20 the resident weighed 146.9 lbs. indicating a 27.50% significant weight gain in the last 6 months.

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F 641	Continued From page 24 On 5/26/21 at approximately 3:00 pm, surveyor spoke with the DON (director of nursing) who stated the MDS has been corrected with the weight of 187.3. On 5/26/21 at 5:00 pm during a meeting with the administrative team including the administrator, DON, human resources, and the regional nurse, surveyor discussed the concern of Resident #61's MDS not being accurately coded for the resident's weight. No further information regarding this issue was presented to the survey team prior to the exit conference on 5/27/21.	F 641		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to ensure that residents who were unable to carry out activities of daily living received the necessary care and services to maintain personal hygiene for 7 of 22 residents, Residents #12, 19, 32, 45, 62, 64 and 11. The findings included: 1. For Resident #12, the facility failed to complete nail care. Resident #12's toenails were observed to be long and jagged.	F 677		

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Resident #12's face sheet included the diagnosis, multiple myeloma, malignant neoplasm of colon, and Parkinson's disease.

Section C (cognitive patterns) of the residents significant change in status (MDS) minimum data set assessment with an (ARD) assessment reference date of 05/01/2021 included a (BIMS) brief interview for mental status summary score of 8 out of a possible 15 points. Section G (functional status) was coded (3/2) for personal hygiene to indicate the resident required extensive assistance of one person for this task.

Resident #12's (CCP) comprehensive care plan included the problem area self-care deficit related to weakness on hospice services with decline anticipated. Approaches included, allow extra time to complete (ADLs) activities of daily living.

05/26/21 4:35 p.m., toenails observed to be long and thick in appearance. The (CNA) certified nursing assistant that accompanied the surveyor during this observation stated hospice had been in today.

05/26/21 5:02 p.m., end of the day meeting with administrator, (DON) director of nursing, (RNC) regional nurse consultant and (HR) human resource personnel #1 and #2. The issue regarding the residents nail care was addressed with these staff. The DON stated it was the responsibility of the CNAs to cut fingernails. The administrator stated they would look at the residents nails and have them taken care of.

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

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2. For Resident #19, the facility staff failed to complete nail care. Resident #19's fingernails and toenails were observed to be long and jagged in appearance.

Resident #19's face sheet included the diagnosis hypothyroidism, multiple sclerosis, and vascular dementia.

Section C of the residents quarterly MDS assessment with an ARD of 02/19/2021 included a BIMS status summary score of 0 out of a possible 15 points. Section G (functional status) was coded (4/3) total dependent on two persons for personal hygiene, dressing, and bathing.

Resident 19's CCP included the problem area self-care deficit related to multiple sclerosis, dementia, dependent on staff to anticipate and meet needs. Approaches included keep nails clean and trimmed.

05/26/2021 11:05 a.m., skin assessment completed with (LPN) licensed practical nurse #2. Resident #19's feet were noted to be dry and flaky and their toenails and fingernails were observed to be jagged and long.

05/26/21 5:02 p.m., end of the day meeting with administrator, DON, RNC, and HR personnel #1 and #2. The issue regarding the residents nail care was reviewed. The DON stated it was the responsibility of the CNAs to cut fingernails. The administrator stated they would look at the residents nails and have them taken care of.

No further information regarding this issue was provided to the survey team prior to the exit

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conference.

3. For Resident #32, the facility failed to complete nail care. Resident #32's fingernails and toenails were observed to long and jagged in appearance.

Resident #32's face sheet included the diagnosis, traumatic subdural hemorrhage, Parkinson's disease, and unspecified dementia.

Section C of the residents quarterly MDS assessment with an ARD of 03/11/2021 included a BIMS score of 9 out of a possible 15 points. Section G was coded (3/2) to indicate the resident required extensive assistance of one person for this task.

Resident #32's CCP included the problem area self-care deficit. Approaches included Provide hands on assist for self-care task while allowing them to do as much for themselves as possible.

05/26/2021 4:38 p.m., up in gerichair fingernails long and toenails long and jagged in appearance. Hospice in today to see patient per CNA.

05/26/21 5:02 p.m., end of the day meeting with administrator, DON, RNC, and HR #1 and #2. These staff were made aware of the issue regarding the residents nails. The DON stated it was the responsibility of the CNAs to cut fingernails. The administrator stated they would look at the residents nails and have them taken care of.

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

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4. For Resident #45, the facility failed to complete nail care. Resident #45's fingernails and toenails were observed to long and jagged in appearance.

Resident #45's face sheet included the diagnosis, cerebral infarction, dysphagia, type 2 diabetes, generalized anxiety disorder.

Section C of Resident #45's significant change MDS assessment with an ARD of 03/12/2021 included a BIMS score of 12 out of a possible 15 points. Section G was coded (2/2) for limited assistance of one person for personal hygiene. Resident #45 was coded to indicate the resident had impairment on both sides in the lower extremities.

Resident #45's CCP included the problem area self-care deficit related to impaired mobility related to past (CVA) cerebrovascular accident and unable to complete self-care tasks. Approaches included keep nails clean and trimmed.

05/26/21 3:12 p.m., Observation of Resident #45's fingernails and toenails completed with CNA #1. The toenails on both feet were observed to be long and jagged in appearance. Some of the nails were noted to be curved in toward the resident's feet. Resident #45 stated they did not have any clippers.

05/26/21 5:02 p.m., end of the day meeting with administrator, DON, RNC, HR personnel #1 and #2. The issues regarding the residents nail care was reviewed. The DON stated it was the responsibility of the CNAs to cut fingernails. The administrator stated they would look at the residents nails and have them taken care of.

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05/27/21 9:42 a.m., fingernails had been trimmed Resident #45 stated the staff had not cut their toenails. Resident #45's feet were covered with blankets and they were reluctant to have the surveyor check their feet. No second observation made per resident request.

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

5. For Resident #62, the facility failed to complete nail care. Resident #62's fingernails were observed to be long in appearance.

Resident #62's face sheet included the diagnosis, hypertensive heart disease, diastolic congestive heart failure, respiratory failure, and schizoaffective disorder.

Section C of the residents quarterly MDS assessment with an ARD of 04/22/2021 included a BIMS score of 13 out of a possible 15 points. Section G was coded (3/2) to indicate the resident required extensive assistance of one person for this tasks.

The residents CCP included the problems area self-care deficit and is at risk for behaviors related to depression and bipolar, may self isolate and resist care.

05/26/2021 4:35 p.m., observed fingernails to be long in appearance refused to let the surveyor look at toenails.

05/26/21 5:02 p.m., end of the day meeting with administrator, DON, RNC, and HR personnel #1

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and #2. The issue regarding the residents nail care was reviewed. The DON stated it was the responsibility of the CNAs to cut fingernails. The administrator stated they would look at the residents nails and have them taken care of.

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

6. For Resident #64, the facility staff failed to complete nail care. Resident #64's fingernails and toenails were observed to be long and curved under in appearance.

Resident #64's face sheet included the diagnosis, Parkinson's disease, benign prostatic hyperplasia, vascular dementia, dementia with lewy bodies, and traumatic subdural hemorrhage without loss of consciousness.

Section C of the resident's quarterly MDS assessment with an ARD of 04/26/2021 included a BIMS score of 5 out of a possible 15 points. Section G was coded (3/2) to indicate the resident required extensive assistance of one person for personal hygiene.

Resident #64's CCP included the problem area impaired ability to bathe/shower and groom self independently related to weakness and cognitive deficit. Approaches included keep nails clean and trimmed.

05/26/2021 4:59 p.m., fingernails observed to be long with debris present. Toenails observed to be long with one toenails on the left foot curved under.

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05/26/21 5:02 p.m., end of the day meeting with administrator, DON, RNC, and HR personnel #1 and #2. The issues regarding the residents nail care was reviewed. The DON stated it was the responsibility of the CNAs to cut fingernails. The administrator stated they would look at the residents nails and have them taken care of.

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

7. For Resident #11, the facility staff failed to provide assistance with showers per the resident's preference of twice weekly.

Resident #11's diagnosis list indicated diagnoses, which included, but not limited to Spondylolisthesis Lumbar Region, Bipolar II Disorder, Hereditary Motor and Sensory Neuropathy, Muscle Wasting and Atrophy, and Epilepsy Unspecified not Intractable without Status Epilepticus.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 4/22/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns. Resident #11 was coded as being totally dependent in bathing.

On 5/26/21 at 9:19 am, surveyor spoke with Resident #11 who stated that they did not get their shower on Monday because there was not enough staff. Resident further stated that this happens often on Mondays. The next morning at 8:58 am, surveyor again spoke with Resident #11 concerning their showers and asked if they receive showers two times per week and the resident stated it "depends if there's enough

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F 677	Continued From page 32 staff". Surveyor asked Resident #11 if they would like a shower twice a week and they stated "yes". Resident #11 stated sometimes (he/she) takes self into the bathroom and gives (his/her) self a "bird bath". Surveyor reviewed Resident #11's Point of Care History report for ADLs (activities of daily living) for showers which included documentation that showers/bed baths were provided seven times from 4/01/21 through 5/26/21 on the following dates: 4/01/21, 4/15/21, 4/26/21, 4/29/21, 5/10/21, 5/17/21, and 5/20/212. The administrator provided a form entitled "SHARE Body Check/Work-up Quality Tool" dated 5/03/21 and stated the form was completed with a shower given that day. Resident #11's current care plan includes an approach stating in part "assist (him/her) with a shower or bath, per (his/her) preference, twice weekly". On 5/27/21 at 1:58 pm during a meeting with the administrator and regional nurse, surveyor discussed the concern of Resident #11 not being assisted with showers twice weekly per their preference. No further information regarding this issue was presented to the survey team prior to the exit conference on 5/27/21.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		

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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 and clinical record review, the facility staff failed to ensure the residents receive treatment and care in accordance with the comprehensive person-centered care plan for 2 of 22 residents, Residents #31 and #19.

The findings included:

1. For Resident #31, facility staff failed to follow physician's orders for the administration of Acidophilus (a probiotic supplement), Baclofen (a skeletal muscle relaxant used to treat pain and certain types of spasticity), Diazepam (a benzodiazepine used to relieve anxiety and control muscle spasms and spasticity), Gabapentin (an anticonvulsant used to control seizures, restless leg syndrome, and relieve nerve pain), and Simethicone (an anti-gas medication).

Resident #31's diagnosis list indicated diagnoses, which included, but limited to Muscle Wasting and Atrophy not Elsewhere Classified Other Site, Unspecified Injury at Unspecified Level of Cervical Spinal Cord, Functional Quadriplegia, Generalized Anxiety Disorder, and Major Depressive Disorder Recurrent Mild.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of

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4/27/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, Cognitive patterns.

Resident #31 has the following active physician orders: Acidophilus (lactobacillus acidophilus) capsule 1 oral twice a day, Baclofen tablet 20 mg 1.5 tablets by mouth four times daily for quadriplegia, Diazepam 5 mg by mouth three times daily, Gabapentin 300 mg 1 capsule by mouth three times daily for quadriplegia, and Mi-Acid Gas Relief (Simethicone) [OTC] tablet 80 mg chewable tablet by mouth at bedtime.

A review of Resident #31's May 2021 MAR (medication administration record) revealed the following medication administration omissions: Acidophilus 5/13/21 10:00 pm and 5/20/21 10:00 pm; Baclofen 5/13/21 10:00 pm, 5/14/21 2:00 pm, and 5/20/21 10:00pm; Diazepam 5/13/21 10:00 pm, 5/14/21 2:00pm, and 5/20/21 10:00 pm; Gabapentin 5/13/21 10:00 pm, 5/14/21 2:00 pm and 5/20/21 10:00 pm; Simethicone 5/13/21 10:00 pm and 5/20/21 10:00 pm.

Resident #31's current care plan addressing pain includes the approach dated 8/16/19 to administer medications as ordered.

On 5/26/21 at 4:36 pm surveyor spoke with the DON (director of nursing) concerning the MAR omissions and the DON stated "I don't have an explanation".

On 5/26/21 at 5:00 pm during a meeting with the administrative team consisting of the administrator, DON, human resources, and the regional nurse, the surveyor discussed the concern of Resident #31's medication

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administration omissions on 5/13/21, 5/14/21, and 5/20/21.

Surveyor spoke with the regional nurse on 5/27/21 at 1:22 pm who stated the agency nurse stated they did give the 2:00 pm medications and it is possible that they may have not hit the save button on the computer.

No further information regarding this issue was presented to the survey team prior to the exit conference on 5/28/21.

2. For Resident #19, the facility staff failed to administer the physician ordered medication Levothyroxine 75 mcg. This medication was available in the stat box located in the facility medication room.

Resident #19's face sheet included the diagnosis hypothyroidism, multiple sclerosis, and vascular dementia.

Section C (cognitive patterns) of the residents quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 02/19/2021 included a (BIMS) brief interview for mental status summary score of 0 out of a possible 15 points.

Resident 19's (EHR) electronic health record included a physician order for Levothyroxine 75 mcg before breakfast. Date of order 02/02/2021.

A review of Resident #19's (EMARs) electronic medication administration records revealed that on 05/14/2021 at 6:00 a.m. the nursing staff documented "Not Administered: Drug/Item Unavailable Comment: reorder" for this medication.

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F 684	Continued From page 36 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. 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. No further information regarding this issue was provided to the surveyor prior to the exit conference.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		

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(d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure pharmacy recommendations were forwarded to the physician and/or the facility and failed to ensure the physician followed up on the recommendations for 2 of 22 residents, Residents #45 and 31.

The findings included:

1. For Resident #45, the contracting pharmacist failed to send a pharmacy recommendation to the physician/facility and failed to ensure the physician followed up on the recommendation.

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Resident #45's face sheet included the diagnosis, cerebral infarction, dysphagia, type 2 diabetes, and generalized anxiety 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.

During the clinical record review, the surveyor was unable to locate a pharmacy review for 02/2021.

05/27/2021, the regional nurse consultant provided the surveyor with a copy of a recommendation dated 02/04/2021 and stated the pharmacist had failed to email this recommendation to the facility and/or physician.

05/27/2021 11:50 a.m., the DON provided the surveyor with a copy the information that indicated the physician had reviewed the recommendation today. The physician wrote on this form do not crush these medications; administer whole crush med order updated.

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

2. For Resident #31, the facility staff failed to report the February 2021 drug regimen review to the attending physician, the facility medical director, and the DON (director of nursing).

Resident #31's diagnosis list indicated diagnoses, which included, but limited to Muscle Wasting and

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Atrophy not Elsewhere Classified Other Site, Unspecified Injury at Unspecified Level of Cervical Spinal Cord, Functional Quadriplegia, Generalized Anxiety Disorder, and Major Depressive Disorder Recurrent Mild.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 4/27/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, Cognitive patterns.

Upon review of Resident #31's clinical record on 5/26/21, surveyor was unable to locate the February 2021 drug regimen review completed by the pharmacist.

On 5/27/21 at 10:54 am, surveyor spoke with the DON who stated they have just spoken with the pharmacist and they did not send the February drug regimen review recommendations to the facility. DON stated the pharmacist is sending the recommendations now. At 11:22 am, the DON provided surveyor with a copy of the February 2021 drug regimen review for Resident #31 entitled "Note To Attending Physician/Prescriber" with the recommendation of "Please evaluate the order for fluoxetine 20 mg every morning to see if a reduction can be tried. CMS guidelines require a periodic review of all psychoactive medication orders to see if the lowest effective dose is being used. Please select one of the following: 1) Reduce dose to the following:, 2) Continue current dose as patient is stable and previous attempts to reduce have failed, 3) A reduction attempt is contraindicated as patient is easily destabilized". The review is dated 2/05/21 and electronically signed by the consultant pharmacist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. BUILDING _____ B. WING _____	C 05/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 40 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 conference on 5/27/21.	F 756		