STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. BUILDING _____ B. WING _____	C 05/12/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 1 drug that meets the criteria set forth in paragraph (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 complete drug regimen reviews for 2 of 18 Residents Resident #28 and #42 and failed to act upon recommendations for 1 of 18 resident #28. The facility staff failed to provide the surveyor with evidence of drug regimen reviews that were completed in March 2022 for Resident #28 and #42 and failed to follow up on pharmacy recommendations for Residents #28. The findings included:	F 756		

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F 756	Continued From page 2 1. Resident #28 had been admitted to the facility after the previous standard survey. Section C (cognitive patterns) of Resident #28's annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/02/22 included a Brief Interview for Mental Status Summary (BIMS) score of 11 out of a possible 15 points. Diagnoses included, but were not limited to, Parkinson's disease, diabetes, chronic kidney disease, and hypertension. During the record review, the surveyor was unable to find any evidence of a drug regimen review that was completed for March 2022. On 05/12/22 9:40 a.m., the Assistant Director of Nursing (ADON) was made aware of the missing drug regimen review for March and stated they had switched over their software system in March 2022. The facility staff provided the surveyor with copies of a pharmacy recommendation dated 09/27/21 requesting the physician to, "Please evaluate the order for Nuplazid 34mg daily for Parkinson's psychosis to see if a reduction can be tried..." The facility was unable to provide any evidence to the surveyor that the physician had followed up on this recommendation. Resident #28's current physician orders included an order for Nuplazid 34 mg 1 cap every am. The facility staff also provided the surveyor with a copy of a pharmacy recommendation with no date. This recommendation referenced the PRN	F 756	Resident #28 & #42 had a complete physician medication regimen review on 5/13/22 by pharmacy consultant and physician. Pharmacy consultant was also made aware of missing MRR and submitted MRR for physician review on 5/13/22. An audit on all resident MRR was conducted by ADON and unit managers on 5/13/22. In order to ensure this deficiency does not recur, ADON will conduct monthly audits for MRR and consult with pharmacy and physician as needed to ensure accurate completion of MRR in a timely manner. All MRR audits will be discussed in weekly PAR meeting by nursing leadership and in monthly QAPI meetings for 3 months. Subsequent plans of correction will be updated and implemented if needed.	5/13/22 5/13/22

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F 756	Continued From page 3 (as needed) medication refresh eye drops "This have gone unused for over 60 days-as such they may not be required to maintain their well being as the issue they were designed to treat may no longer be active problems. Consider DCing (discontinuing) each for these reasons." Resident #28's current physician orders included an order for Refresh eye drops every 12 hours as needed for itchy eyes 2 drops each eye. There was no documentation to indicate it had been administered for the month of May 2022. On 05/12/22 at 10:52 a.m., Licensed Practical Nurse (LPN) #4 was asked for any information regarding the above-mentioned pharmacy recommendations. On 05/12/22 at 12:50 p.m., LPN #4 stated they had no further information on the Nuplazid or Refresh eye drops. On 05/12/22 at 12:06 p.m., the Administrator, Director of Nursing (DON), ADON, and unit managers were made aware of the missing drug regimen review for March 2022. The surveyor also requested evidence that the recommendations had been followed up on by the physician. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. Section C (cognitive patterns) of Resident #42's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/31/22 included a Brief Interview for Mental Status Summary (BIMS) score of 11 out of a possible 15 points.	F 756		

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F 756	Continued From page 4 Diagnoses included, but were not limited to chronic obstructive pulmonary disease, diabetes, and hypertension. During the record review, the surveyor was unable to find any evidence of a drug regimen review that was completed in March 2022. On 05/12/22 at 9:40 a.m., the Assistant Director of Nursing (ADON) stated they were missing a pharmacy review for this resident from March 2022 and they had switched over their software in March. On 05/12/22 at12:06 p.m., the Administrator, Director of Nursing (DON), ADON, and unit managers were made aware of the missing drug regimen review for March 2022. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 756		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		

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F 842	Continued From page 5 professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842		

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F 842	Continued From page 6 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure a complete, and accurately documented clinical record for 1 of 18 residents in the survey sample (Resident #45). For Resident #45, the facility staff failed to document the resident's blood glucose readings. The findings included: Resident #45's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 3, Acute on Chronic Congestive Heart Failure, Paranoid Schizophrenia, Bipolar II Disorder, and Chronic Respiratory Failure. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 3/28/22 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating Resident #45 was moderately cognitively impaired.	F 842	Documentation that was required for resident #45 blood sugar orders was immediately corrected by unit manager on 5/10/2022. The order was corrected to include a requirement for nursing staff to document blood sugar results in the MAR. ADON/Unit managers will conduct a second check on all blood sugar orders within 24 hours of order entry to ensure correct documentation requirements were entered beginning on 5/11/2022. ADON educated licensed nursing staff on documentation policy and procedure on 5/10/22 and 5/11/22. Monthly audits will be completed by ADON and unit managers to ensure correct order entry on blood sugar monitoring and documentation. These audits will be discussed in monthly QAPI meetings for 3 months or until substantial compliance is achieved which began 5/23/22. Subsequent plans of correction will be updated and implemented if needed.	5/10/22 5/11/22

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F 842	Continued From page 7 Upon surveyor review on 5/10/22, Resident #45's current physician's orders included an order dated 3/28/22 for accuchecks twice daily and notify MD/NP (nurse practitioner) of blood glucose less than 60 or above 400. Surveyor reviewed Resident #45's clinical record and the last documented blood glucose reading was documented on 3/28/22 at 6:11 am. A review of the resident's medication administration records (MARs) from 3/28/22 through 5/10/22 included documentation indicating the resident's blood glucose levels were checked twice a day on day and evening shifts, however, the blood glucose readings were not documented on the MARs. The most recent blood glucose reading documented on the resident's blood glucose log in the clinical record was dated 3/28/22 at 6:07 am. On 5/11/22 at 11:25 A.M., surveyor spoke with licensed practical nurse (LPN) #4 regarding Resident #45's blood glucose readings. LPN #4 stated that they have corrected the order to include documentation of the resident's blood glucose, and the nurse working today had some of the missing blood sugars written down on their notes that were not documented in the resident's clinical record. LPN #4 returned at 12:25 P.M. and provided blood glucose readings for 3/28/22, 4/01/22, 4/02/22, 4/05/22, 4/15/22, 4/16/22, 4/25/22, 4/29/22, 4/30/22, 5/02/22, 5/03/22, and 5/09/22. LPN #4 stated that they had checked with all the nurses that worked, and this was all of the blood sugars the nurses had written down on paper. On 5/12/22 at 10:46 A.M., surveyor again spoke with LPN #4 who stated the new electronic health	F 842		

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F 842	Continued From page 8 record system went live on 3/10/22, and when the Accucheck order was entered into the system the requirement for special documentation of the blood glucose reading was not added. Surveyor requested and received the facility policy entitled "Obtaining a Fingerstick Glucose Level" which read in part "The person performing this procedure should record the following information in the resident's medical record...6. The blood sugar results..." On 5/12/22 at 12:08 P.M., surveyor met with the management team including the administrator, director of nursing, assistant director of nursing, nursing supervisor, and unit managers and discussed the concern of Resident #45's clinical record not including blood sugar reading. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/12/22.	F 842		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency;	F 886		

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F 886	Continued From page 9 (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who	F 886		

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F 886	Continued From page 10 refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and document review the facility staff failed to properly implement COVID-19 testing processes and/or procedures for 1 of 1 COVID-19 staff testing observations, CNA#1. An observation of the staffing coordinator (CNA#1) obtaining a COVID-19 nasal swab test for one licensed practical nurse (LPN) identified the specimen was not collected according to manufacturer's instructions. The findings were: On 5/10/2022 at 2:38 p.m., the staffing coordinator (CNA#1) was observed obtaining a COVID-19 nasal swab test from a licensed practical nurse (LPN). Prior to obtaining the LPN's specimen, CNA#1 described the process for swabbing the nostrils. She reported rotating the swab inside each nare for approximately 5 seconds each side. The surveyor observed CNA#1 place the swab inside one nostril and rotate it 5 times and then repeating the process in the other nostril. The surveyor timed the collection which lasted 6-7 seconds in total. CNA#1 acknowledged she rotated the swab for about 3 seconds in each nostril and reported being taught how to collect the specimens and	F 886	On 5/10/2022, CNA #1 was educated by ADON on correct COVID-19 testing policy, procedure, and manufacturer's instructions. Nursing staff were educated on swabbing procedure on 5/10/22 by infecton preventionist.. A mandatory skills day for all nursing staff is scheduled for 6/22/22 & 6/23/22 to demonstrate competency prior to testing residents or staff for COVID-19. ADON/unit managers will provide reeducation on proper procedure for covid 19 testing. Infection Preventionist will conduct random observations weekly to ensure testing procedures are being executed correctly. These audits will be discussed in monthly QAPI meetings for 3 months. Subsequent plans of correction will be updated and implemented if required.	5/10/22 5/10/22 6/23/22

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F 886	Continued From page 11 run the tests by a previous director of nursing. CNA#1 provided the manufacturer's instructions for the BinaxNOW COVID-19 Ag CARD tests she used to collect the LPN's sample. The specimen collection and handling "Anterior Nasal (Nares) Swab" read, "Only the swab provided in the kit is to be used for nasal swab collection. To collect a nasal swab sample, carefully insert the entire absorbent tip of the swab (usually 1/2 to 3/4 of an inch (1 to 1.5 cm) into the nostril. Firmly sample the nasal wall by rotating the swab in a circular path against the nasal wall 5 times or more for a total of 15 seconds, then slowly remove from the nostril. Using the same swab, repeat sample collection in the other nostril." On 05/10/2022 at approximately 3:00 p.m., the administrator, nursing supervisor, and CNA#1 were informed the manufacturer's instructions read to rotate the swab for 15 seconds in each nare The administrator read the manufacturer's instructions and acknowledged the swab should be rotated for 15 seconds in each nare. No further information was provided prior to the exit conference.	F 886		

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/10/22 through 05/12/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaint(s) were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/10/22 through 05/12/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. VA00053903-Substaniated no deficient practice. The Life Safety Code survey/report will follow. The census in this 107 certified bed facility was 87 at the time of the survey. The final survey sample consisted of 18 current resident reviews.	F 000		
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	F 756		

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

T Bulgen BN, LNHA | Administrator | 6-1-22

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.