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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. BUILDING _____ B. WING _____	C 02/16/2023

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 2/13/23 through 2/16/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The overall operations of the facility are maintained within the State and Federal guidelines. The results of this survey reflect a small sample of residents within a small period of time. This Plan of Correction is submitted solely to meet requirements established by State and Federal law	4/1/23
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 2/13/23 through 2/16/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey: 1. VA00055913- unsubstantiated 2. VA00053159- unsubstantiated The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 76 at the time of the survey. The survey sample consisted of 24 current Resident reviews and 3closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580	F 580 Corrective Action(s): The facility provided notification to the family of Resident #61 of the weight loss, the episode of rectal bleeding, and subsequent orders immediately following the surveyor findings. Identification of Deficient Practices/Corrective Action(s): The DON/designee performed an audit of all other residents with significant weight losses and significant changes throughout the facility to ensure their resident representative has been notified. The facility did not identify any additional residents with significant weight losses where their representative had not been notified. Nursing department educated to report significant weight losses, significant changes, and subsequent orders to resident representatives. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The DON/designee will report clinical changes, subsequent orders, and the facility's Dietician will discuss those residents with significant weight losses during the facility's weekly risk meeting. A review to ensure the resident representative being notified will occur during this time as well. Monitoring: The DON/designee and Dietician/designee will be responsible for monitoring compliance. These individuals will report episodes of non-compliance to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which reviews need to be continued.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hale Simmons	Administrator	3/14/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. BUILDING _____ B. WING _____	C 02/16/2023

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 580	Continued From page 1 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F 580		

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 02/16/2023

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 580	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on resident representative interview, staff interview, clinical record review, and facility document review, the facility staff failed to notify the resident representative of significant changes in the resident's physical condition for 1 of 24 residents in the survey sample, Resident #61. The findings included: For Resident #61, the facility staff failed to notify the resident representative of significant weight loss in a timely manner and failed to notify of an episode of rectal bleeding. Resident #61's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Chronic Atrial Fibrillation, Chronic Respiratory Failure with Hypoxia, Chronic Conjunctivitis, Unspecified Blepharitis, and Repeated Falls. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/19/23 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired. Resident #61 was coded as requiring limited assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. Resident #61 was coded for a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months while not on a physician-prescribed weight-loss regimen. On 2/14/23 at 3:51 pm, surveyor spoke with Resident #61's adult child who stated they were not being notified with all health changes,	F 580		

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 02/16/2023

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 580	Continued From page 3	F 580		

medication changes or when the doctor comes in.

A review of Resident #61's clinical record revealed the following resident weights:
10/06/22 - 113.0
1/23/23 - 104.5
2/03/23 - 99.4

Resident #61's clinical record included a 1/25/23 quarterly nutrition assessment by the RD (registered dietitian) which documented in part " ...Wt [weight] 3 months ago 113# with a 7% wt loss in 3 months and 6 months ago wt 124# with a 15% wt loss in 6 months. Ubw [usual body weight] 124# Currently on Ensure plus 240 ml BID [twice a day] which provided 350 kcals and 20 grams protein for each. Encourage intakes at meals and snacks and description of foods and location for vision. Recommend increase to Ensure Plus TID [three times a day] for added Kcals and protein and monthly wts".

Resident #61's clinical record included a Nutrition Risk Note dated 2/09/23 stating "Res [resident] on Regular diet and Ensure BID BMI [body mass index] has decreased in past month to 19.4. Wt on 2/03 99.4# Wt 2 weeks ago 104.5# which is a significant wt loss of 5%. Wt 6 months ago 125# and significant 21% wt loss in 6 months. Recommended increasing ensure nutrition supplement to TID [three times a day] or keep Ensure BID and add magic cup daily - resident preference. Monitor wts and encourage intakes at meals and snacks".

Surveyor reviewed the resident's clinical record and was unable to locate documentation of Resident #61's resident representative being notified of the weight losses identified on 1/23/23

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 02/16/2023

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 580	Continued From page 4 or 2/03/23 until 2/15/23. A 2/15/23 5:53 am late entry nursing note for 2/14/23 stated in part "[family nurse practitioner (FNP)] notified of recent weight loss, RD recommendations. New orders noted to obtain CMP [complete metabolic panel], CBC [complete blood count] now, obtain weekly weights and document for review. Attempt made to notify Rp [responsible party], will retry in AM". A 2/15/23 1:39 pm nursing note stated "Late entry - approx. 0900 2/15/23 - Notified RP of new orders, recent weight loss and condition. RP states [he/she] would like an update when lab results returned and MD review". Resident #61 was seen by the FNP on 12/22/22 for rectal bleeding with plans to hold the anticoagulant Eliquis for 5 days, check stools for occult blood on two occasions, obtain CBC level, iron saturation level, ferritin level, and total iron binding capacity level, and start the medication Protonix. Surveyor reviewed Resident #61's clinical record and was unable to locate documentation of the resident representative being notified of the rectal bleeding or subsequent orders. Surveyor requested and received the facility policy entitled "Change in a Resident's Condition or Status" which read in part "Our facility shall notify the resident, his or her Attending Physician, and/or resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.)". On 2/16/23 at 5:22 pm, the survey team met with	F 580		

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 02/16/2023

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 580	Continued From page 5 the administrator, DON, and nurse consultant and discussed the concern of Resident #61's resident representative not being notified timely of weight loss or an episode of rectal bleeding with subsequent orders. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/16/23.	F 580		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility staff failed to complete a Significant Change Minimum Data Set (MDS) assessment for one (1) of 24 residents, Resident #68. The findings include: The facility staff failed to complete a Significant Change Minimum Data Set (MDS) assessment when Resident #68 started receiving hospice care.	F 637		

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 02/16/2023

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 637	Continued From page 6 Resident #68's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/11/23, was signed as completed on 1/11/23. Modifications to this MDS assessment were documented on 2/14/23 and 2/16/23. Resident #68 was assessed as rarely or never able to make self understood and as rarely or never able to understand others. Resident #68 was assessed as the Brief Interview for Mental Status should not be completed due to the resident being "rarely/never understood." Resident #68 was documented a being dependent on others for bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #68 had an order for "consult for hospice care and to treat if approved" dated 11/29/22. Documentation indicated the hospice admission was delayed until 12/7/22 at the request of one of the resident's family members. On 2/15/23 at 2:10 p.m., Registered Nurse (RN) #1 was interviewed about Resident #68's MDS assessments. RN #1 reported a significant change MDS assessment had not been completed when Resident #68 started receiving hospice services. On 2/15/23 at 2:52 p.m., RN #1 stated a significant change MDS had been started with an Assessment Reference Date (ARD) of 2/15/23. On 2/16/23 at 5:23 p.m., the survey team conducted a meeting with the facility's Administrator, Director of Nursing, and a Nurse Consultant. The surveyor discussed the failure of facility staff members to complete a significant change MDS assessment when Resident #68 started receiving hospice care.	F 637	F 637 Corrective Action(s): A corrected MDS assessment for Resident #68 has been completed and submitted at time of survey. Identification of Deficient Practices/Corrective Action(s): Other residents who have elected hospice services have been audited by DON/designee to ensure a significant change assessment has been performed. One other resident was identified as not having a significant change completed when electing hospice services. A corrected MDS has been submitted for this resident as well. MDS department educated on accurate and thorough MDS assessments of residents receiving hospice services. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The MDS Coordinator/ designee will report any new residents with a hospice diagnosis during the facility's weekly risk meeting. At this time the MDS Coordinator/designee will ensure a significant change assessment has been performed. Monitoring: The MDS Coordinator/designee will be responsible for monitoring compliance. To assist with compliance monitoring, the MDS Coordinator/designee will report any episodes in which a hospice diagnosis was selected, and a significant change assessment was not performed to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	4/1/23

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 02/16/2023

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 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 interviews and document reviews, the facility staff failed to ensure Minimum Data Set (MDS) assessments accurately reflected residents' conditions for two (2) of 24 residents, Resident #68 and Resident #70. The findings include: 1. Resident #68's Minimum Data Set (MDS) assessment (with an Assessment Reference Date (ARD) of 1/11/23) had the resident assessed as both able to make self understood and as being "rarely/never understood." Resident #68's MDS assessment, with an ARD of 1/11/23, was signed as completed on 1/11/23. Resident #68 was assessed as able to make self understood and as able to understand others. Resident #68 was also assessed not to have the Brief Interview for Mental Status completed due to the resident being "rarely/never understood." Resident #68 was documented a being dependent on others for bed mobility, transfers, dressing, toilet use, and personal hygiene. On 2/14/23 at 4:04 p.m., the surveyor discussed Resident #68's conflicting MDS data with the facility's Administer. On 2/16/23, the survey team was provided with a modified MDS assessment that had Resident #68's assessment modified to change (a) able to	F 641	F 641 Corrective Action(s): Both MDS assessments for Resident #68 and Resident #70 have been corrected and submitted at time of survey. Identification of Deficient Practices/Corrective Action(s): An audit of all resident BIMS scores and appropriate assessment of section B and C will be completed. Any other residents throughout the facility that have had an incorrect MDS assessment will have a corrected MDS assessment performed and submitted. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The facility's MDS department and Social Services department reeducated on consistent and accurate assessments within Section B and Section C. An audit of all resident BIMS scores and appropriate assessment of section B and C will be completed. Correction MDS will be sent as necessary. A sample size audit will be completed by the facility's MDS Coordinator/designee, and those findings will be submitted during the weekly risk meeting. Monitoring: The facility's MDS Coordinator/designee will be responsible for monitoring compliance. To assist with compliance monitoring, the MDS Coordinator/designee will submit the MDS Section B and Section C audited and discussed weekly to the interdisciplinary team. The facility's Administrator/designee will be responsible for implementing additional education, disciplinary action, and process changes to ensure compliance is maintained. The findings from these audits, along with the corrective action will be presented to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	4/1/23

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 02/16/2023

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 641	Continued From page 8	F 641		

make self understood and able to understand others to (b) rarely/never able to make self understood and rarely/never able to understand others.

On 2/16/23 at 5:23 p.m., the survey team conducted a meeting with the facility's Administrator, Director of Nursing, and a Nurse Consultant. The surveyor discussed the Resident #68's MDS assessment including conflicting information related to the resident's ability to be understood.

2. Resident #70's Minimum Data Set (MDS) assessment (with an Assessment Reference Date (ARD) of 11/25/22) had the resident assessed as both able to make self understood and as being "rarely/never understood."

Resident #70's MDS assessment, with an ARD of 11/25/22, was signed as completed on 12/7/22. Resident #70 was assessed as able to make self understood and as able to understand others. Resident #70 was assessed not to have the Brief Interview for Mental Status completed due to the resident being "rarely/never understood." Resident #70 was assessed as being independent with transfers, dressing, and toilet use.

On 2/14/23 at 4:04 p.m., the surveyor discussed Resident #70's conflicting MDS data with the facility's Administer.

The surveyor was provided a copy of a modified MDS assessment (with an ARD of 11/25/22) that had Section C modified to remove the information indicating the Brief Interview for Mental Status should not be completed, for Resident #70, due

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 02/16/2023

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 641	Continued From page 9 to the resident being "rarely/never understood." This was modified on 2/14/23. On 2/16/23 at 5:23 p.m., the survey team conducted a meeting with the facility's Administrator, Director of Nursing, and a Nurse Consultant. The surveyor discussed the Resident #70's MDS assessment including conflicting information related to the resident's ability to be understood.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. BUILDING _____ B. WING _____	C 02/16/2023

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 656	Continued From page 10 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: 3. The facility staff failed to develop a care plan to address Resident #68's hospice needs. Resident #68's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/11/23, was signed as completed on 1/11/23. Modification to this MDS assessment were documented on 2/14/23 and 2/16/23. Resident #68 was assessed as rarely or never able to make self understood and as rarely or never able to understand others. Resident #68 was assessed as the Brief Interview for Mental Status should not be completed due to the resident being "rarely/never understood." Resident #68 was documented a being dependent on others for bed mobility, transfers, dressing, toilet use, and personal hygiene.	F 656	F 656 Corrective Action(s): The facility has updated Resident #68, #59, and #61's care plans to reflect their specific individualized needs. Identification of Deficient Practices/Corrective Action(s): The facility has performed a 100% care plan audit of other residents with like needs and have made adjustment to their care plans as indicated. MDS department has been reeducated on appropriate and accurate care plans. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The MDS Coordinator, or designee will review those residents discussed during the weekly risk meeting to ensure those residents with changes to their condition have an update care plan to discuss their needs. Monitoring: The MDS Coordinator/designee will be responsible for monitoring compliance. To assist with compliance monitoring, the MDS Coordinator/designee will perform an audit of all resident care plans and will report those findings to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	4/1/23

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 02/16/2023

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 656	Continued From page 11 Resident #68 had an order for "consult for hospice care and to treat if approved" dated 11/29/22. Documentation indicated the hospice admission was delayed until 12/7/22 at the request of one of the resident's family members. On 2/15/23 at 2:10 p.m., Registered Nurse (RN) #1 was interviewed about Resident #68's care plan. RN #1 reported Resident #68's comprehensive care plan did not address the resident's hospice care. On 2/15/23 at 2:20 p.m., RN #1 provided the surveyor a copy of Resident #68's Hospice Care Plan which had a start date of 2/15/23. On 2/16/23 at 5:23 p.m., the survey team conducted a meeting with the facility's Administrator, Director of Nursing, and a Nurse Consultant. The surveyor discussed Resident #68's not having a hospice care plan developed when the resident started receiving hospice care. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to implement a comprehensive person-centered care plan to meet the needs of	F 656		

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 02/16/2023

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 656	Continued From page 12	F 656		

the resident for 3 of 24 residents in the survey sample, Resident #61, #59, and #68.

The findings included:

1. For Resident #61, the facility staff failed to implement the comprehensive person-centered care plan intervention of bilateral mats placed to both sides of the bed.

Resident #61's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Chronic Atrial Fibrillation, Chronic Respiratory Failure with Hypoxia, Chronic Conjunctivitis, Unspecified Blepharitis, and Repeated Falls.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/19/23 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired. Resident #61 was coded as requiring limited assistance with bed mobility, transfers, dressing, eating, tollet use, and personal hygiene.

A review of Resident #61's comprehensive person-centered care plan revealed a care plan description documenting in part at risk for falls, bilateral mats placed to both sides of bed.

Throughout the course of the survey, surveyor made eight visual observations of Resident #61, on each observation, the resident was in bed. On four of the eight observations, the floor mats were not in place per the care plan.

On 2/14/23 at 2:19 pm and 5:01 pm, Resident

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 02/16/2023

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 656	Continued From page 13 #61 was in bed and the bilateral floor mats were folded up and located on each side near the head of the bed. At 5:02 pm, surveyor requested licensed practical nurse (LPN) #4 accompany the surveyor into the resident's room. Surveyor asked LPN #4 if the floor mats should be in place on each side of the bed and LPN #4 stated yes and placed the floor mats in position on each side of the bed. On 2/15/23 at 8:25 am and 12:04 pm, surveyor observed Resident #61 in bed with the right floor mat in place and the left floor mat folded up and placed on top of the resident's chest of drawers near the foot of the bed. Surveyor requested and received the facility policy entitled "Care Plans, Comprehensive Person-Centered" which read in part "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident". On 2/16/23 at 5:22 pm, the survey team met with the administrator, director of nursing, and the nurse consultant and discussed the concern of Resident #61's bilateral floor mats not being in place per the resident's plan of care. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/16/23. 2. For resident #59 the facility staff failed to implement a comprehensive person-centered care plan.	F 656		

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 02/16/2023

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 656	Continued From page 14	F 656		

The findings include:

Resident #59's diagnoses included, but were not limited to, Alzheimer's disease, chronic kidney disease, anxiety disorder, and major depressive disorder.

The admission minimum data set (MDS) with an assessment reference date (ARD) of 1/18/23, assigned the resident a brief interview for mental status (BIMS) score of 3, indicating severe cognitive impairment. Under Section G for functional status, resident #59 is coded as dependent on staff for all activities of daily living (ADL's). Section H reveals resident is always incontinent of bowel and bladder.

2/15/23 at 10:15 A.M. Surveyor observed resident with an anxious, pained facial expression while interviewing their spouse. Resident was fidgeting with the bed covers, grimacing and would repeatedly point to the bathroom. Resident asked surveyor, "Is it busy? Is somebody in there"? Spouse stated that resident thinks they need to use the restroom and won't settle down. Surveyor went to locate a staff member to assist resident with toileting. RN #2 informed surveyor that spouse had said the son was coming to assist. Surveyor approached the facility administrator in the hall, explained the situation and asked that they check on resident. Administrator reported to surveyor at 10:43 A.M. that resident had been toileted and given a laxative. Surveyor noted at 1:20 P.M. resident was resting quietly with his eyes closed.

2/15/23 2:44 P.M. Surveyor requested a copy of the comprehensive care plan for resident #59.

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 02/16/2023

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 656	Continued From page 15 The regional nurse consultant brought the baseline care plan, and a care plan for advanced directives. There was no other care plan available in the medical record that addressed toileting, anxiety, or incontinence. 2/16/23 9:20 A.M. Surveyor interviewed RN #1. Surveyor asked if resident should have a comprehensive care plan completed in the medical record as they were admitted 1/11/23 and the admission MDS was signed as complete on 1/23/23. RN #1 confirmed that the care plan should be complete, and that it would be done by the end of day. On 2/16/23 at 5:09 P.M. Surveyor reviewed this concern with the Administrator, Director of Nursing the regional nurse consultant. No further information was received prior to exit.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility staff failed to ensure clinical documentation supported new diagnoses for two (2) of 24 residents, Resident #68 and Resident #50. The findings include: 1. Resident #68's clinical documentation included	F 658		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. BUILDING _____ B. WING _____	C 02/16/2023

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 658	Continued From page 16 the diagnosis of "Schizoaffective disorder, unspecified" dated 12/21/22. Resident #68's clinical documentation failed to include assessment information to support the addition if this diagnosis. Resident #68's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/11/23, was signed as completed on 1/11/23. Modification to this MDS assessment were documented on 2/14/23 and 2/16/23. Resident #68 was assessed as rarely or never able to make self understood and as rarely or never able to understand others. Resident #68 was assessed as the Brief Interview for Mental Status should not be completed due to the resident being "rarely/never understood." Resident #68 was documented a being dependent on others for bed mobility, transfers, dressing, toilet use, and personal hygiene. The following information was found in a document titled "DIAGNOSIS CLARIFICATION REQUEST" which addressed Resident #68's diagnoses: "Can we utilize (diagnosis) ... schizoaffeclive disorder due to (resident) being on Seroquel?" This document was signed by a medical provider on 12/21/22 but the medical provider did not document whether or not the diagnosis of schizoaffective disorder should be used. On 2/15/23 at 1:15 p.m., the surveyor interviewed the facility's Medical Director about Resident #68's Schizoaffective Disorder diagnosis. The Medical Director reported they would contact the psychiatric nurse practitioner for information related to this diagnosis.	F 658	F 658 Corrective Action(s): The facility has updated Resident #50 and #68's MDS and medical record to accurately reflect their current diagnosis. Identification of Deficient Practices/Corrective Action(s): The facility has performed a 100% audit of other residents with antipsychotic medications and no additional residents were identified as needing correction. The MDS department has been reeducated on appropriate diagnoses associations. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The MDS Coordinator, or designee will review those residents on antipsychotic medications during the weekly risk meeting to ensure those residents on antipsychotic medication reflect the correct physician diagnosis. Monitoring: The MDS Coordinator will be responsible for monitoring compliance. To assist with compliance monitoring, the MDS Coordinator will perform an audit of all residents with antipsychotic medications and will report those findings to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	4/1/23

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 02/16/2023

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 658	Continued From page 17 On 2/16/23 at 9:22 a.m., the surveyor interviewed the facility's Medical Director via telephone. The Medical Director reported the diagnosis of Schizoaffective Disorder should be removed due to the lack of supporting documentation. On 2/16/23 at 3:48 p.m., the facility's Director of Nursing (DON) provided documentation which indicated Resident #68's diagnosis of "Schizoaffective disorder, unspecified" had been "retracted." On 2/16/23 at 5:23 p.m., the survey team conducted a meeting with the facility's Administrator, Director of Nursing, gand a Nurse Consultant. The surveyor discussed the failure of facility staff members to have supporting documentation for Resident #68's diagnosis of Schizoaffective Disorder resulting in a medical provider removing the diagnosis. 2. Resident #50's clinical documentation included the diagnosis of "Schizoaffective disorder, unspecified" dated 12/21/22. Resident #50's clinical documentation failed to include assessment information to support the addition if this diagnosis. Resident #50's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/9/23, was signed as completed on 2/3/23. Resident #50 was assessed as able to make self understood and able to understand others. Resident #50's Brief Interview for Mental Status summary score was documented as an 8 out of 15; this indicated moderate cognitive impairment. Resident #50 was assessed as being independent with bed mobility and eating. Resident #50 was assessed as requiring	F 658		

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 02/16/2023

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 658	Continued From page 18 assistance with personal hygiene and bathing. On 2/16/23 at 9:22 a.m., the surveyor interviewed the facility's Medical Director via telephone. The Medical Director was asked about Resident #50's diagnosis of Schizoaffective Disorder. No documentation supporting the addition of Resident #50's Schizoaffective Disorder diagnosis was provided to the surveyor. On 2/16/23 at 3:48 p.m., the facility's Director of Nursing (DON) provided documentation which indicated Resident #50's diagnosis of "Schizoaffective disorder, unspecified" had been "retracted." On 2/16/23 at 5:23 p.m., the survey team conducted a meeting with the facility's Administrator, Director of Nursing, and a Nurse Consultant. The surveyor discussed the failure of facility staff members to have supporting documentation for Resident #50's diagnosis of Schizoaffective Disorder resulting in a medical provider removing the diagnosis.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		

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 02/16/2023

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 684	Continued From page 19 Based on facility document review and clinical record review, and staff interview facility staff failed to provide treatment as ordered for one of 24 current residents in the survey sample (Resident # 176). Resident #176 was admitted to the facility on 2/9/2023. The resident's diagnoses included primary adrenocortical insufficiency, ploryneuropathy, chronic obstructive pulmonary disease, polymyalgia rheumatica, common variable immunodeficiency, morbid obesity type 2 diabetes mellitus, chronic pancreatitis, depression, anxiety, muscle spasms, nausea, allergies, edema, primary adrenocortical insufficiency, hypertension, and insomnia. At the time of the survey, the resident did not yet have a minimum data set assessment. The surveyor interviewed the resident on 2/13/2023 and found the resident knowledgeable about diagnoses and treatment and able to answer questions about the time in the facility. The resident expressed no concerns other than lack of medication availability and not having received a fentanyl patch (due every third day) since admission on 2/9. The resident stated although there was an as-needed pain medication order, lack of fentanyl resulted in significant pain. The surveyor reviewed the clinical record on 2/13/2023 and discovered that fentanyl 75mcg transdermal patch apply 1 patch every 72 hours at 10 AM was ordered on admission on 2/9/23. Staff documented fentanyl N= not administered-other on 2/10 and 2/13/2023. A nursing progress note dated 2/12/2023 at 2:02 PM stated 'On Call provider [name] notified of need for scripts to be sent to pharmacy for Gabapentin and Percocet". The surveyor was unable to locate documentation	F 684	F 684 Corrective Action(s): The facility has updated Resident #17's physician and resident of the findings surrounding medications and treatments being held without rationale. Identification of Deficient Practices/Corrective Action(s): The DON/designee has performed a medication and treatment audit and have notified resident representatives and physicians of any medications and/or treatments that were held/not administered without rationale. The nursing department has been educated on holding medication/treatments and utilizing rationale documentation. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The DON/designee will perform weekly medication and treatment audits to ensure compliance. Monitoring: The DON /designee will be responsible for monitoring compliance. To assist with compliance monitoring, DON/designee perform an audit of all resident medication administration and treatment records and will report those findings to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	4/1/23

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 02/16/2023

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 684	Continued From page 20 of need for prescription needed for fentanyl. Review of the Medication Administration Record (MAR) on 2/15/2023 revealed the following medications documented as N=not administered without explanation on 2/12-2/14: 2/12 8AM- Golytely, incruse ellipta 9AM- Gabapentin 9PM- methacarbamol 2/13 5AM- methacarbamol 8AM- Adair discus, Golytely 11AM- venlafaxine 8PM-topiramate, ursodiol, Lunesta 9 PM- methacarbamol 2/14 1AM- methacarbamol 5AM- methacarbamol 8AM-Golytely 12PM-diclofenac gel 6PM-diclofenac gel 9PM-methacarbamol There was no evidence that the physician/physician surrogate had been notified of any of the medications not being administered. The surveyor spoke with the director of nursing on 2/14/2023 and requested a print-out of the MAR and notes associated with the MAR. During a brief interview on 2/16/2023 at 9:40 AM, the nurse caring for the resident, Licensed Practical Nurse (LPN) #5, stated that nurses were expected to document reasons for not administering ordered medications and treatments. During a summary meeting on 2/14/2023 which included the administrator and DON, the surveyor asked about availability of pain medication. The DON reported that a fentanyl patch had been	F 684		

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 02/16/2023

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 684	Continued From page 21 placed on the resident that day. During a summary meeting on 2/16/2023, the surveyor reported the medications in addition to fentanyl listed above that were documented as not administered without explanation.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to provide pressure ulcer treatment as ordered for one of 24 current residents in the survey sample (Resident #5). Resident #5 was admitted to the facility with diagnoses including hypertension, peripheral vascular disease, gastroesophageal reflux, muscle weakness, major depression, osteoarthritis, cognitive communication deficit and polyneuropathy. On the minimum data set assessment with assessment reference date 12/8/2022, the resident scored 15/15 on the brief interview for mental status and was assessed as	F 686		

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 02/16/2023

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 686	Continued From page 22 without signs of delirium, psychosis, or behaviors affecting treatment. The resident was assessed as having one unhealed stage two pressure ulcer and application of non-surgical dressing. During clinical record review, the surveyor noted an order to "Cover pressure area to buttock with Mepilex change daily until healed" dated 11/25 and discontinued on 12/03/2022. The Treatment Administration Record indicated the treatment N=not administered, other, see note on 11/27-11/29/2022. The nurse's notes did not state reasons the treatments were not administered or that the physician/physician surrogate had been notified that the treatments were not administered. During a brief interview on 2/16/2023 at 9:40 AM, the nurse caring for the resident, Licensed Practical Nurse (LPN) #5, stated that nurses were expected to document reasons for not administering ordered medications and treatments. The surveyor spoke with the Director of Nursing (DON) on 12/16/2023. The DON stated that the nurse should document the reasons when medications or treatments were not administered. During a summary meeting on 12/16/2023, the administrator was notified of the concern that treatments were not administered and that the reasons were not documented.	F 686	F 686 Corrective Action(s): The facility has updated Resident #5's physician and resident representative of the findings surrounding the treatment being held without rationale. Identification of Deficient Practices/Corrective Action(s): The DON/designee has performed a medication and treatment audit and have notified resident representative and physicians of any medications and/or treatments that were held/not administered without rationale. The nursing department has been educated on holding medication/treatments and utilizing rationale documentation. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The DON/designee will perform weekly medication and treatment audits to ensure compliance. Monitoring: The DON /designee will be responsible for monitoring compliance. To assist with compliance monitoring, DON/designee perform an audit of all resident medication administration and treatment records and will report those findings to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued	4/1/23
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. BUILDING _____ B. WING _____	C 02/16/2023

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 692	Continued From page 23 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that residents maintain acceptable parameters of nutritional status for 1 of 24 residents in the survey sample, Resident #61. The findings included: For Resident #61, the facility staff failed to administer the nutritional supplement Ensure as ordered by the physician and failed to follow the registered dietician's (RD) recommendations to increase the amount of Ensure or add the nutritional supplement Magic Cup. The facility staff also failed to ensure the resident's weight loss was addressed by the provider in a timely manner.	F 692	F 692 Corrective Action(s): The facility has updated Resident 61's physician and resident representative of the findings surrounding RD recommendations and resident change in condition. Identification of Deficient Practices/Corrective Action(s): The DON/Designee has performed a dietary recommendation audit and have notified resident representatives and physicians of any dietary recommendations as well as significant changes that weren't documented as being completed and/or the physician being notified. Reeducation provided to nursing department to ensure proper transcriptions, appropriate notifications and significant weight changes to resident representative and physician. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The Director of Nursing, or designee in conjunction with the Dietician will perform weekly medication and treatment order audits as well as weight losses to ensure compliance. Monitoring: The Director of Nursing and Dietician will be responsible for monitoring compliance. To assist with compliance monitoring, Director of Nursing and Dietician will perform an audit of administration and treatment records as well as weight losses and will report those findings to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	4/1/23

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 02/16/2023

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 692	Continued From page 24 Resident #61's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Chronic Atrial Fibrillation, Chronic Respiratory Failure with Hypoxia, Chronic Conjunctivitis, Unspecified Blepharitis, and Repeated Falls. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/19/23 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired. Resident #61 was coded as requiring limited assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. Resident #61 was coded for a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months while not on a physician-prescribed weight-loss regimen. A review of Resident #61's clinical record revealed the following resident weights: 10/06/22 - 113.0 1/23/23 - 104.5 2/03/23 - 99.4 Surveyor was unable to locate documentation of weights between 10/06/22 through 1/23/23. At the time of the clinical record review on 2/13/23, Resident #61's current diet order was a regular diet with regular texture and thin liquids. The resident had a current order dated 10/27/22 for Ensure Plus 240 ml twice daily as a supplement. A review of Resident #61's medication administration records (MARs) following the 10/27/22 order revealed the resident had not received the Ensure. Further investigation revealed the order was entered for	F 692		

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 02/16/2023

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 692	Continued From page 25 the Ensure to be administered twice a day every 120 days. On 2/14/23 at 4:20 pm, the survey team met with the administrator, director of nursing, and the nurse consultant and discussed the concern of Resident #61 not receiving Ensure as ordered. A 1/25/23 quarterly nutrition assessment by the RD documented in part " ...Wt [weight] 3 months ago 113# with a 7% wt loss in 3 months and 6 months ago wt 124# with a 15% wt loss in 6 months. Ubw [usual body weight] 124# Currently on Ensure plus 240 ml BID [twice a day] which provided 350 kcals and 20 grams protein for each. Encourage intakes at meals and snacks and description of foods and location for vision. Recommend increase to Ensure Plus TID [three times a day] for added Kcals and protein and monthly wts". Surveyor was unable to locate corresponding orders or documentation addressing the RD's recommendation to increase Ensure Plus to three times a day. Resident #61's clinical record included a Nutrition Risk Note dated 2/09/23 stating "Res [resident] on Regular diet and Ensure BID BMI [body mass index] has decreased in past month to 19.4. Wt on 2/03 99.4# Wt 2 weeks ago 104.5# which is a significant wt loss of 5%. Wt 6 months ago 125# and significant 21% wt loss in 6 months. Recommended increasing ensure nutrition supplement to TID [three times a day] or keep Ensure BID and add magic cup daily - resident preference. Monitor wts and encourage intakes at meals and snacks".	F 692		

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 02/16/2023

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 692	Continued From page 26 Surveyor was unable to locate corresponding orders or documentation addressing the RD's recommendation to again increase Ensure Plus to TID or add Magic Cup. A new order dated 2/14/23 was entered to increase Ensure Plus to 240 ml three times a day. On 2/16/23 at 11:11 am, surveyor spoke with the RD via phone regarding Resident #61. The RD stated they saw a couple of weeks ago that the recommendation to increase Ensure was not done and thought maybe Resident #61 did not like Ensure and recommended to increase to TID or add a Magic Cup daily. RD stated recently there was an email glitch where their dietary recommendations were not sent out for three to five days. The RD explained the process for dietary recommendations as they write the resident progress notes with the recommendations and then type a nutritional recommendation report listing all the residents seen and the new recommendation and then emails the list to the facility staff including two CDMs (certified dietary manager), MDS nurse, head nurse, DON (director of nursing), and recently added the administrator to the list. A 2/15/23 5:53 am late entry progress note for 2/14/23 stated the FNP (family nurse practitioner) was notified of recent weight loss and RD recommendations with new orders to obtain CMP (complete metabolic panel), CBC (complete blood count) now and obtain weekly weights and document for review. Surveyor reviewed Resident #61's clinical record and was unable to locate documentation of the attending physician or FNP being notified of the	F 692		

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 02/16/2023

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 692	Continued From page 27 resident's weight loss prior to 2/14/23. On 2/16/23 at 9:28 am, surveyor spoke with Resident #61's attending physician via phone and asked if they were notified of the resident's weight loss prior to this week and they stated they did not see a note where they had addressed a weight loss. On 2/16/23 at 5:22 pm, the survey team met with the administrator, DON, and nurse consultant and discussed the concern of Resident #61's Ensure and lack of provider notification of weight loss. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/16/23.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: 2. The facility staff failed to assess respiratory status for Resident #125. Resident #125 was COVID-19 positive at the time of admission. On the afternoon of 2/13/23, Resident #125 was observed to be resting in bed, coughing. Resident #125's Minimum Data Set (MDS)	F 695		

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 02/16/2023

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 695	Continued From page 28 assessment had yet to be completed at the time of the survey. Review of Resident #125's clinical documentation failed to reveal evidence of a respiratory exam until approximately 38 hours after the resident's arrival to the facility. The following information was found in a facility policy titled "Coronavirus Disease (COVID-19) - Identification and Management of Ill Residents" (with a revised date of September 20212): - "Residents are monitored daily for signs of respiratory infection and/or symptoms of COVID-19, including: a. fever (temperature (greater than or equal to) 100.0 (degrees Fahrenheit) and/or chills; b. cough; c. shortness of breath or difficulty breathing; d.fatigue; e. muscle or body aches; f. headache; g. new loss of taste or smell; h. sore throat; i. congestion or runny nose; j. nausea or vomiting; and/or k. diarrhea." - "Clinical monitoring of residents with suspected or confirmed SARS-CoV-2 infection is increased, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious infections." On 2/13/23 at 3:17 p.m., the surveyor interviewed the facility's Director of Nursing (DON) about Resident #125's respiratory assessments. The DON reported a general respiratory assessment should be completed every shift for a resident that is COVID-19 positive. On 2/16/23 at 5:23 p.m., the survey team conducted a meeting with the facility's Administrator, Director of Nursing, and a Nurse	F 695	F 695 Corrective Action(s): The facility performed a respiratory assessment on Resident #125 and ensured Resident #61 was receiving the correct amount of oxygen per the physician order. The facility also notified the physician and resident representative of each resident to alert them of the findings. Identification of Deficient Practices/Corrective Action(s): The DON/designee has performed an audit of all Oxygen orders and ensuring proper liters were being administered as ordered. All covid positive residents were audited for compliance of respiratory assessments completed. Additionally, staff education surrounding respiratory assessments for covid positive residents and administering oxygen as ordered completed. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The Director of Nursing, or designee will perform weekly medication and treatment audits to ensure compliance with oxygen administration as well as respiratory assessments for covid positive residents completed as needed. Monitoring: The DON/designee will be responsible for monitoring compliance. To assist with compliance monitoring, DON/designee will perform an audit of oxygen orders and administration as well as respiratory assessments for covid positive residents and will report those findings to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	4/1/23

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 02/16/2023

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 695	Continued From page 29	F 695		

Consultant. The surveyor discussed the failure of facility staff members to complete the required respiratory examination/assessment for Resident #125 (a resident who was positive for COVID-19).

Based on observation, staff interview, and clinical record review, the facility staff failed to provide respiratory care consistent with the comprehensive person-centered care plan for 2 of 24 residents in the survey sample, Resident #61 and #125.

The findings included:

1. For Resident #61, the facility staff failed to administer oxygen as ordered by the physician and according to the resident's comprehensive person-centered care plan.

Resident #61's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Chronic Atrial Fibrillation, Chronic Respiratory Failure with Hypoxia, Chronic Conjunctivitis, Unspecified Blepharitis, and Repeated Falls.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/19/23 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired. Resident #61 was coded as requiring limited assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. The resident was also coded as receiving oxygen therapy within the last 14 days.

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 02/16/2023

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 695	Continued From page 30	F 695		

Resident #61's current physician's orders included an active order dated 6/14/22 for oxygen at 3 liters continuous.

The resident's current comprehensive person-centered care plan included the care plan description "Receiving oxygen therapy d/t [due to] chronic respiratory failure with hypoxia" with an intervention stating, "Administer oxygen therapy as ordered - Oxygen at 3 LPM [liters per minute] via NC [nasal cannula]".

On five separate occasions, 2/13/23 at 3:54 pm, 2/14/23 at 2:19 pm, 2/15/23 at 8:29 am, 2/15/23 at 12:04 pm, and 2/15/23 at 1:14 pm, surveyor observed Resident #61 in bed receiving oxygen via nasal cannula at the delivery rate of 2 LPM per the oxygen concentrator setting. At each observation, the oxygen concentrator was located on the left near the head of the bed out of the resident's reach.

On 2/15/23 at 1:14 pm, surveyor approached licensed practical nurse (LPN) #5 and requested they accompany the surveyor to Resident #61's room to verify the oxygen setting, however, LPN #5 was unable to assist at that time. Surveyor returned to Resident #61's room later that afternoon at 2:54 pm and the oxygen concentrator was set at 3 LPM. Surveyor spoke with LPN #5 who stated they checked the resident's oxygen and sometimes the concentrators get bumped. When asked what setting the concentrator was running at when checked, LPN #5 stated it looked like 3 ½ to 4.

On 2/15/23 at 4:11 pm, the survey team met with the administrator, director of nursing, and the

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 02/16/2023

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 695	Continued From page 31 nurse consultant and discussed the concern of Resident #61 not receiving oxygen at the physician ordered rate of 3 LPM. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/16/23.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure that residents who require dialysis receive services consistent with the comprehensive person-centered care plan for 1 of 24 residents in the survey sample, Resident #42. The findings included: For Resident #42, the facility staff failed to monitor the resident's hemodialysis access site for adequate blood flow and complications. Resident #42's diagnosis list indicated diagnoses, which included, but not limited to Hypertensive Heart Disease, Chronic Kidney Disease, End Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus, and Schizoaffective Disorder.	F 698		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. BUILDING _____ B. WING _____	C 02/16/2023

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 698	Continued From page 32 The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/21/22 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #42 was coded as receiving dialysis within the past 14 days. Resident #42's comprehensive person-centered care plan included a care plan description stating in part renal disease: requires dialysis with an intervention to monitor shunt for patency. Surveyor reviewed Resident #42's clinical record and was unable to locate consistent documentation of the monitoring of the resident's hemodialysis access site. During the past 30 days, surveyor was able to locate clinical record documentation addressing the resident's access site on one occasion. A nursing note dated 2/03/23 at 4:05 pm read in part " ...Shunt in place. No bleeding noted ..." On 2/15/23 at 3:02 pm, surveyor spoke with the director of nursing (DON) and requested how shunt care was being documented. At 3:15 pm, surveyor again spoke with the DON and nurse consultant and asked if there should be hemodialysis access monitoring orders and the nurse consultant stated it was debatable but was best practice. The DON stated all resident dialysis sites were assessed yesterday and they are putting in monitoring orders now. Surveyor requested and received the facility policy entitled "Hemodialysis Access Care" which read in part: Care of AVFs [arterio-venous fistula] and AVGs	F 698	F 698 Corrective Action(s): The facility has updated Resident #42's physician and resident of the findings surrounding the dialysis shunt assessment being omitted and implemented shunt monitoring order for Resident #42. Identification of Deficient Practices/Corrective Action(s): The DON/Designee has performed a medication and treatment audit and have notified resident representatives and physicians of any dialysis shunt assessments that weren't documented as being completed. Implemented shunt monitoring orders for all dialysis resident with a shunt. Reeducated licensed nursing staff surrounding dialysis site assessments was completed. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The DON/designee will perform weekly audits surrounding compliance of dialysis site assessments. Monitoring: The DON/designee will be responsible for monitoring compliance. To assist with compliance monitoring DON/designee will perform an audit of all dialysis residents and will report those findings to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	4/1/23

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 02/16/2023

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 698	Continued From page 33 [arterio-venous graft] 4. To prevent infection and/or clotting: d. Check for signs of infection (warmth, redness, tenderness or edema) at the access site when performing routine care and at regular intervals. h. Check patency of the site at regular intervals. Palpate the site to feel the "thrill," or use a stethoscope to hear the "whoosh" or "bruit" of blood flow through the access. On 2/15/23 at 4:11 pm, the survey team met with the administrator, DON, and nurse consultant and discussed the concern of Resident #42's hemodialysis access site not being consistently monitored. On 2/16/23 at 2:35 pm, the DON stated Resident #42's orders have been corrected to monitor the shunt site and also for all other residents receiving dialysis. On 2/16/23, surveyor again reviewed Resident #42's clinical record and a physician's order dated 2/15/23 stated "Dialysis: Check Thrill and Bruit to dialysis shunt Q [every] shift - Left fistula access site". No further information regarding this concern was presented to the survey team prior to the exit conference on 2/16/23.	F 698		
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	F 756		

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 02/16/2023

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 34 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 (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 interviews and document review, the facility staff failed to ensure Medication Regimen Reviews (MRRs) were addressed by a medical	F 756	F 756 Corrective Action(s): The facility has updated Resident #68 and #61's physician and resident representative of the findings surrounding the medication regimen reviews from September and October of 2022. Identification of Deficient Practices/Corrective Action(s): The facility has performed a medication regimen review audit on all residents for 2023. All have been addressed and completed timely. Reeducation provided to DON regarding timely completion of medication regimen review. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The DON/designee will perform monthly medication regiment review audits to ensure compliance. Monitoring: The DON/designee will be responsible for monitoring compliance. To assist with compliance monitoring DON/designee will perform an audit of medication regimen reviews and will report those findings to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	4/1/23

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 02/16/2023

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 35 provider for two (2) of 24 residents, Resident #68 and Resident #61. The findings include: 1. The facility staff failed to ensure two (2) of Resident #68's Medication Regimen Reviews (MRRs) were documented and addressed by a medical provider. Resident #68's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/11/23, was signed as completed on 1/11/23. Modification to this MDS assessment were documented on 2/14/23 and 2/16/23. Resident #68 was assessed as rarely or never able to make self understood and as rarely or never able to understand others. Resident #68 was assessed as the Brief Interview for Mental Status should not be completed due to the resident being "rarely/never understood." Resident #68 was documented a being dependent on others for bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #68's clinical documentation included the following notes: - On 8/29/22 at 1:40 p.m., "Medication regimen has been reviewed. MD note; (as needed) to be submitted." - On 10/30/22 at 5:57 p.m., "Medication regimen has been reviewed. MD note to be submitted." Resident #68's clinical documentation failed to include what recommendations were made at the time of the aforementioned medication regimen reviews. The following information was found in a facility document titled "Medication Regimen Reviews"	F 756		

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 02/16/2023

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 36 (with a revised date of May 2019): - "Within 24 hours of the MRR, the Consultant Pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. The report contains: a. The resident's name; b. The name of the medication; c. The identified irregularity; and d. The pharmacist's recommendation." - "The Consultant Pharmacist provides the Director of Nursing Services and Medical Director with a written, signed and dated copy of all medication regimen reports." - "Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record." On 2/16/23 at 8:11 a.m., the facility's Director of Nursing (DON) reported they were unable to find the documentation for Resident #68's two (2) aforementioned MRRs. On 2/16/23 at 5:23 p.m., the survey team conducted a meeting with the facility's Administrator, Director of Nursing, and a Nurse Consultant. The surveyor discussed the failure of facility staff members to ensure details of Resident #68's MRRs were documented; the surveyor discussed the failure of facility staff members to ensure Resident #68's MRRs was acted on by a medical provider. 2. For Resident #61, the facility staff failed to provide evidence of the September 2022 and October 2022 drug regimen reviews being reported to the attending physician, the facility medical director, and the director of nursing	F 756		

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 02/16/2023

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 37 (DON).	F 756		

Resident #61's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Chronic Atrial Fibrillation, Chronic Respiratory Failure with Hypoxia, Chronic Conjunctivitis, Unspecified Blepharitis, and Repeated Falls.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/19/23 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired. Resident #61 was coded as requiring limited assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene.

Upon review of Resident #61's clinical record on 2/15/23, surveyor was unable to locate the September 2022 and October 2022 drug regimen review reports completed by the pharmacist.

The resident's clinical record included a progress note dated 9/27/22 stating "Medication regimen has been reviewed. MD Note; stop date to be submitted". Resident #61's clinical record also included a 10/30/22 progress note stating "Medication regimen has been reviewed. MD note; NN to be submitted". Surveyor was unable to locate the corresponding medication regimen reviews.

On 2/15/23 at 4:11 pm, the survey team met with the administrator, DON, and the nurse consultant and discussed the concern of Resident #61's September 2022 and October 2022 drug regimen reviews not being available in the clinical record.

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 02/16/2023

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 38 On 2/16/23 at 2:40 pm, surveyor spoke with the DON who stated they did not have the September 2022 or October 2022 drug regimen reviews. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/16/23.	F 756		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident representative interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure residents are free of any significant medication errors for 1 of 24 residents in the survey sample, Resident #61. The findings included: For Resident #61, the facility staff failed to provide three antibiotics as ordered for severe bilateral conjunctivitis and failed to hold the anticoagulant, Eliquis, as ordered by the provider following an episode of rectal bleeding. Resident #61's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Chronic Atrial Fibrillation, Chronic Respiratory Failure with Hypoxia, Chronic Conjunctivitis, Unspecified Blepharitis, and Repeated Falls.	F 760		

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 02/16/2023

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 760	Continued From page 39 The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/19/23 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired. Resident #61 was coded as requiring limited assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. On 2/14/23 at 3:46 pm, surveyor spoke with the resident's adult child who expressed concern regarding the resident's history of eye infections. A review of Resident #61's clinical record revealed that the resident was seen at the (name omitted) Eye Center on 9/30/22. The consult report stated in part that the resident's diagnosis was severe bilateral MRSA (Methicillin-resistant Staphylococcus Aureus) bacterial conjunctivitis not responding to maximum topical treatment and the recommendation was patient needed Infectious Disease consult ASAP and likely needed long term systemic antibiotic therapy. Resident #61 was seen by Infectious Disease on 10/13/22. The consult report documented a diagnosis of severe bilateral conjunctivitis and gave the following antibiotic medication orders: Polymyxin B + Trimethoprim ophthalmic solution 1-2 drops in each eye every 4 hours for 10 days Bactrim Solution 10 ml by mouth twice a day for 10 days Rifampin 300 mg by mouth every day for 10 days Surveyor reviewed Resident #61's October 2022 Medication Administration Record (MAR) which revealed the following medication administration errors: Polymyxin B + Trimethoprim was administered	F 760	F 760 Corrective Action(s): The facility has updated Resident #61's physician and resident representative of the findings surrounding the physician's orders not being followed as prescribed. Identification of Deficient Practices/Corrective Action(s): The facility has performed a medication/treatment audit and have notified resident representatives and physicians of any medications and/or treatments that weren't documented as being completed as ordered. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The DON/designee will perform weekly medication audits to ensure compliance. Education to licensed nursing professionals regarding transcription of orders and documentation completed. Monitoring: The DON/designee will be responsible for monitoring compliance. To assist with compliance monitoring, DON/designee will perform an audit of all new orders to ensure accuracy of order transcription and will report those findings to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	4/1/23

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 02/16/2023

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 760	Continued From page 40	F 760		

four times a day for 11 days instead of the ordered direction of every 4 hours for 10 days
Bactrim was administered for 11 days instead of the ordered 10-day duration
Rifampin was only administered for one day instead of 10 days as ordered

On 2/16/23 at 8:53 am, surveyor spoke with the director of nursing (DON) and discussed the concern of Resident #61 not receiving the antibiotics as ordered by Infectious Disease on 10/13/23.

On 2/16/23 at 9:28 am, surveyor spoke with Resident #61's attending physician regarding the Infectious Disease orders and asked if it was their intention for the facility to follow the orders from the consult and the physician stated "yes".

On 2/16/23 at 1:36 pm, surveyor spoke with the nurse consultant who confirmed that according to the documentation, Resident #61 did not receive the antibiotic medications as ordered attributing the errors to order entry errors.

At the time of the survey, Resident #61 was receiving Tobrex 0.3% (an antibiotic medication) eye ointment twice daily as ordered on 2/14/23. Throughout the course of the survey, Resident #61's eyes did not appear red or swollen and no drainage was noted from eyes.

Resident #61's clinical record included a 12/22/22 provider progress note indicating the resident was seen by the family nurse practitioner (FNP) for rectal bleeding. In part, the FNP ordered to hold the anticoagulant medication Eliquis for five days. At the time of the progress note, Resident #61 had a current order for Eliquis 5 mg twice a day in

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 02/16/2023

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 760	Continued From page 41 the morning and at bedtime. According to Resident #61's December 2022 MAR, the bedtime dose was held for six consecutive days and the morning dose was only held on 12/23/22 and 12/29/22 (day six following the order). On 2/16/23 at 8:53 am, surveyor spoke with the DON and discussed the concern of Resident #61's Eliquis not being held as ordered. No additional information was provided by the facility. On 2/16/23 at 5:22 pm, surveyor met with the administrator, DON, and nurse consultant and discussed the concern of Resident #61 not receiving antibiotic medication as ordered and Eliquis not being held as ordered. No further information regarding these concerns were presented to the survey team prior to the exit conference on 2/16/23.	F 760		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide laboratory services to meet the needs of the resident for 1 of 24 residents in the	F 770		

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 02/16/2023

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 770	Continued From page 42 survey sample, Resident #61. The findings included: For Resident #61, the facility staff failed to obtain a complete blood count (CBC), iron saturation level, ferritin level, total iron binding capacity level, and failed to check stool for occult blood as order by the medical provider on 12/22/22 due to rectal bleeding. Resident #61's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Chronic Atrial Fibrillation, Chronic Respiratory Failure with Hypoxia, Chronic Conjunctivitis, Unspecified Blepharitis, and Repeated Falls. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/19/23 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired. Resident #61 was coded as requiring limited assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. Resident #61's clinical record included a provider progress note dated 12/22/22 indicating the resident was seen by the family nurse practitioner (FNP) for rectal bleeding. According to the progress note, the documented plan by the FNP in part was for staff to obtain a complete blood count (CBC), iron saturation level, ferritin level, total iron binding capacity level, and check the resident's stool for occult blood on two occasions. Upon review of Resident #61's clinical record,	F 770	F 770 Corrective Action(s): The facility has updated Resident #61's physician and resident representative of the findings surrounding the labs ordered on 12/22/22 as not being completed. Identification of Deficient Practices/Corrective Action(s): The facility has performed laboratory audits and have notified resident representatives and physicians of any labs that weren't documented as being completed. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The DON/designee will perform weekly lab audits to ensure compliance. Education to nursing staff provided regarding lab tracking to ensure labs ordered are completed. Monitoring: The DON/designee will be responsible for monitoring compliance. To assist with compliance monitoring, DON/designee will perform an audit of all labs weekly and will report those findings to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	4/1/23

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 02/16/2023

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 770	Continued From page 43 surveyor was unable to locate evidence of the lab tests being completed. Resident #61's December 2022 eMAR (electronic medication administration record) notes included documentation that the resident refused occult blood stool checks on 12/24/22 at 2:09 pm, 12/24/22 at 5:51 pm, and 12/25/22 at 12:04 pm. However, the 1/19/23 MDS coded the resident as always incontinent of bowel. Surveyor was unable to locate documentation of Resident #61's bowel movements from 12/22/22 through 12/31/22 in the clinical record. Surveyor requested documentation of the resident's bowel movements; however, the facility did not provide the documentation. Surveyor requested and received the facility policy entitled "Lab and Diagnostic Test Results - Clinical Protocol" which read in part: Assessment and Recognition 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests.	F 770		
	On 2/15/23 at 4:11 pm, the survey team met with the administrator, director of nursing, and the nurse consultant and discussed the concern of the missing lab testing for Resident #61. On 2/16/23 at 1:45 pm, surveyor met with the nurse consultant who stated they did not see where the lab testing had been completed in the lab system. The nurse consultant also stated they would expect the nurse to continue to retry the occult blood stool tests.			

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 02/16/2023

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 770	Continued From page 44 No further information regarding this concern was presented to the survey team prior to the exit conference on 2/16/23.	F 770		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to distribute and serve food in accordance with professional standards for food service safety as evidenced by a final rinse temperature below 180 degrees Fahrenheit (F) for a high temperature (heat sanitization) dishwasher in the facility kitchen. The findings included:	F 812		

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 02/16/2023

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 812	Continued From page 45 The facility staff failed to consistently maintain a final rinse temperature at the manufacturer recommended minimum temperature of 180 degrees F for the facility high temperature dishwasher. On 2/13/23 at 2:10 pm, the surveyor observed the facility dishwasher in use. The dietary manager (DM) stated the machine was a high temperature dishwasher. Dishwasher wash and rinse temperature gauges were located on the front of the machine. The wash temperature reached a maximum of 150 degrees F, and the rinse temperature reached a maximum temperature of 170 degrees F. The DM stated the rinse temperature should be 180 degrees F and proceeded to empty and drain the machine and ran another cycle. At that time the wash temperature reached a maximum of 164 degrees F, and the rinse temperature again reached a maximum temperature of 170 degrees F. The DM stated the facility has a new heat booster waiting to be installed for the dishwasher. Surveyor asked the DM if they had any other temperature measuring methods such as a temperature disc for the dishmachine and they stated no. Therefore, surveyor was unable to measure the ware surface temperature of the dishmachine. A data plate affixed to the side of the dishwasher identified the machine as Model: ES-2000HT with a minimum wash temperature of 150 degrees F and a minimum rinse temperature of 180 degrees F. On 2/13/23 at 2:35 pm, surveyor notified the administrator of the dishwasher only reaching a maximum rinse temperature of 170 degrees F.	F 812	F 812 Corrective Action(s): The facility has worked with its vendor to switch the dishwasher to a chemical rinse and wash system, whereby the current temperature range is acceptable. Identification of Deficient Practices/Corrective Action(s): The facility continues to work with the vendor as well as the local health department to ensure compliance. Additionally, the facility will purchase a plate thermometer to ensure the temperature is accurate. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The Director of Dining/designee will perform weekly audits of the dishwasher temperatures to ensure compliance. Education to dining services staff completed to ensure proper dishwasher monitoring is completed and findings reported to dining services manager. Monitoring: The Director of Dining/designee will be responsible for monitoring compliance. To assist with compliance monitoring, Director of Dining/designee will perform temperature check and report any temperatures outside of compliance to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in facility policy, procedure, practice, and length in which audits need to be continued.	4/1/23

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 02/16/2023

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 812	Continued From page 46 On 2/13/23 at 5:35 pm, surveyor met with the administrator in training (AIT) and the (company name omitted) service technician in the facility kitchen. The heat booster had been installed, however, the rinse temperature continued to reach only 170 degrees F. The service technician stated they could convert the dishwasher to a low temperature machine with chemical sanitizer tomorrow. At 5:45 pm, the administrator, AIT, and the service technician approached the surveyor and stated the dishwasher would be converted to a low temperature machine in the morning and the evening meal dishes would be washed to remove debris only and paper products would be used until the machine was repaired. Surveyor requested and received the dish machine temperature logs for the past three months. The December 2022 "Dishmachine Temperature Log (High Temperature)" log was designed to document the wash and rinse temperatures three times a day labeled as breakfast, lunch, and dinner. In each rinse column heading 180 degrees F was documented. An additional column was labeled "Action Taken if Out of Range". From 12/07/22 through 12/31/22, the rinse temperature was recorded below 180 degrees F on 48 of 60 occasions with the recorded range being between 168 degrees F to 178 degrees F. On each day of December when the rinse temperature was below 180 degrees F, the action taken column was blank. The January 2023 dishwasher log was labeled "High Temperature Dishwasher Log", the log included the statement "acceptable temperatures: wash min [minimum]	F 812		

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 02/16/2023

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 812	Continued From page 47 150 [degrees] & final rinse min [minimum] 180 [degrees]". Rinse temperatures were recorded from 1/01/23 through 1/26/23 breakfast with 75 of 76 readings documenting a rinse temperature below 180 degrees F. The documented rinse temperatures ranged from a minimum of 168 to a maximum of 178 degrees F. The dishwasher was documented as not working from 1/26/23 lunch though 1/31/23 dinner. On 1/05/23 and 1/12/23 "fixed" was documented in the "Action taken" column. The February 2023 log documented the machine as not working 2/01/23 through 2/02/23. All rinse temperatures from 2/03/23 through 2/13/23 lunch was documented between the range of 170 degrees F to 175 degrees F. On 2/15/23 at 11:40 am, surveyor spoke with the AIT who stated the dishwasher manufacturer stated the machine should be performing at 180 degrees F and recently had the company come in and check the internal temperature of the machine. The AIT provided information from the service company and the most recent local "Food Establishment Inspection Report" dated 1/13/23. A letter from the dishwasher service provider dated 1/19/23 read in part "This letter is written to verify the proper method to ensure proper Dishmachine water temperatures for hot water sanitation. There are multiple water temperature requirements for water utilized in a commercial dishmachine. For hot water sanitation, these water temperature requirements are found on the data plate affixed in a visible location on the Dishmachine of interest. The dataplate will state required minimum wash temperature and rinse temperatures for proper sanitation among other requirements for proper operation. The FDA food	F 812		

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 02/16/2023

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 812	Continued From page 48	F 812		

code has requirements for hot water sanitation stating that the Dishmachine must achieve at least the desirable minimum temperatures on the Dishmachine data plate as well as a ware temperature of 160 degrees F ...To validate the Dishmachine temperatures either the gauges on the Dishmachine, if they exist, or a manual method may be used to determine proper operating temperatures for proper sanitation. This performed in combination with the ware surface indicator strip with a minimum ware surface temperature of 160 [degrees] F validate proper ware sanitation".

A (company name omitted) "Regular Service Call" report dated 1/11/23 documented in part a rinse temperature of 170 degrees F and included the comment "Incoming water temp low temp and low pressure. Booster heater needed to achieve required rinse temp of 180".

The facility provided 1/13/23 "Food Establishment Inspection Report" completed by the local health district read in part
" Warewashing Info: Machine Name: Sanitization Method: High Temperature Thermo Label: PPM: Sanitizer Name: Sanitizer Type: Temperature: 170 [degrees] F".

Surveyor requested and received the facility policy entitled "Dishwashing Machine Use" which read in part:
3. Dishwashing machine hot water sanitation rinse temperatures may not be more than 194 [degrees] F, or less than:
a. 165 [degrees] F for stationary rack, single temperature machines.
b. 170 [degrees] F for all other machines.

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 02/16/2023

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 812	Continued From page 49 On 2/15/23 at 4:11 pm, the survey team met with the administrator, director of nursing, and the nurse consultant and discussed the concern of the facility dishwasher not consistently reaching the required minimum rinse temperature of 180 degrees F on multiple occasions since December 2022. On 2/16/23 at 5:55 pm, the AIT provided an email exchange dated 2/15/23 between the AIT and the local health district inspector in which the AIT questioned "Based off this information, an internal rinse temperature of 160 or above means that we are in compliance, correct?". The response from the inspector read in part "That is correct ..." On 2/14/23, the facility dishwasher was converted to a low temperature dishwasher using chemical sanitation. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/16/23.	F 812		
F 842 SS=E	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		

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 02/16/2023

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 842	Continued From page 50 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	F 842 Corrective Action(s): The facility's nurse practitioner corrected residents #68 and #50's medication regimen review with rationale for refusing the gradual dose reduction. Resident #70 and physician was notified of the results of his right ear being flushed. Resident #125 had an admission assessment completed with no progress note documented on admission with time of arrival. Resident #176 and facility physician was notified of medications not administered/held without rationale. Identification of Deficient Practices/Corrective Action(s): DON/designee completed audits for medication regimen review for 2023, no further issues identified. Reeducation to providers to include rationale when completing medication regimen review. DON/designee completed audits for all residents with ear flushing orders to ensure results are documented. No further residents with current ear flush orders identified. Reeducation to staff to ensure results are documented when completed. All admissions audited for completion of admission progress note to include time of arrival. Reeducation to licensed nursing professionals to include time of arrival in admission note and complete admission in a timely manner. Medication and treatment order audits completed and reviewed, physician and resident representatives notified of any medications not administered/held without rationale. Reeducation to nursing staff competed to ensure documentation of rationale for not administering/holding medications. Systemic Change(s): The facility's policies and procedures were reviewed, and no changes are needed at this time. The DON/designee will perform medication regimen review, medication/treatment order, admission, and ear flush order audits weekly /monthly to ensure compliance. Monitoring: The Director of Nursing/designee will be responsible for monitoring compliance. To assist with compliance monitoring, DON/Designee will perform an audit of all medication/treatment orders and admissions weekly, medication regimen review to be completed monthly and will report those findings to the Quality Assurance Committee for review, analysis, and additional	4/1/23

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 02/16/2023

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 842	Continued From page 51 §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 interviews and document reviews, the facility staff failed to maintain complete and accurate clinical records for five (5) of 24 residents, Resident #50, Resident #68, Resident #70, Resident #125, and Resident #176. The findings include: 1. Resident #50's Medication Regimen Review (MRR) dated 12/30/22 failed to include documentation of the medical provider's reason for not attempting a Gradual Dose Reduction (GDR). Resident #50's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/9/23, was signed as completed on 2/3/23. Resident #50 was assessed as able to make self understood and able to understand others. Resident #50's Brief Interview for Mental Status summary score was documented as an 8 out of 15; this indicated moderate cognitive impairment. Resident #50 was assessed as being independent with bed mobility and eating.	F 842		

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 02/16/2023

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 842	Continued From page 52 Resident #50 was assessed as requiring assistance with personal hygiene and bathing. The following information was found in a facility document titled "Charting and Documentation" (dated as revised July 2017): - "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." - "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate." Resident #50's "Consultant Pharmacist Recommendation to Physician" dated 12/30/22 included the following request: "Federal guidelines state antipsychotic drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with at least 1 month between attempts, then annually thereafter. This resident has been taking Quetiapine 100 mg since 6/20/2022 without a GDR. Could we attempt a dose reduction at this time to perhaps Quetiapine 75 mg to verify this resident is on the lowest possible dose? If not, please indicate response below ..." This "Consultant Pharmacist Recommendation to Physician" document indicated the medical provider marked the following option: "The drug, dose, duration and indications are clinically appropriate; further reductions are contraindicated due to ..." The medical provider failed to provide a reason for not attempting the	F 842		

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 02/16/2023

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 842	Continued From page 53 GDR. On 2/16/23 at 12:20 p.m., Nurse Practitioner (NP) #6 was interviewed about the aforementioned MRR. NP #6 confirmed they did not want to attempt the GDR. NP #6 stated they would document the reason for not attempting the GDR. The surveyor was provided a copy of the aforementioned "Consultant Pharmacist Recommendation to Physician" document what included the following note dated 2/16/23: "condition would likely decline as result of med reduction". On 2/16/23 at 5:23 p.m., the survey team conducted a meeting with the facility's Administrator, Director of Nursing, and a Nurse Consultant. The surveyor discussed the failure of facility staff members to ensure the medical provider documented the reason for declining to attempt a GDR for Resident #50's quetiapine order. 2. Resident #68's Medication Regimen Review (MRR) dated 12/30/22 failed to include documentation of the medical provider's reason for not attempting a Gradual Dose Reduction (GDR). Resident #68's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/11/23, was signed as completed on 1/11/23. Modification to this MDS assessment were documented on 2/14/23 and 2/16/23. Resident #68 was assessed as rarely or never able to make self understood and as rarely or never able to understand others. Resident #68 was assessed as the Brief Interview for Mental	F 842		

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 02/16/2023

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 842	Continued From page 54 Status should not be completed due to the resident being "rarely/never understood." Resident #68 was documented a being dependent on others for bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #68's "Consultant Pharmacist Recommendation to Physician" dated 12/30/22 included the following request: "Federal guidelines state antipsychotic drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with at least 1 month between attempts, then annually thereafter. This resident has been taking Quetiapine 12.5 mg since 7/1/2022 without a GDR. Could we attempt a dose reduction at this time to perhaps Quetiapine 12.5 mg (every other day) to verify this resident is on the lowest possible dose? If not, please indicate response below ..." This "Consultant Pharmacist Recommendation to Physician" document indicated the medical provider marked the following option: "The drug, dose, duration and indications are clinically appropriate; further reductions are contraindicated due to ..." The medical provider failed to document provide a reason for not attempting the GDR. On 2/16/23 at 12:20 p.m., Nurse Practitioner (NP) #6 was interviewed about the aforementioned MRR. NP #6 confirmed they did not want to attempt the GDR. NP #6 stated they would document the reason for not attempting the GDR. The surveyor was provided a copy of the aforementioned "Consultant Pharmacist Recommendation to Physician" document what	F 842		

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 02/16/2023

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 842	Continued From page 55 included the following note dated 2/16/23: "condition would likely decline as result of med reduction". On 2/16/23 at 5:23 p.m., the survey team conducted a meeting with the facility's Administrator, Director of Nursing, and a Nurse Consultant. The surveyor discussed the failure of facility staff members to ensure the medical provider documented the reason for declining to attempt a GDR for Resident #50's quetiapine order. 3. The facility staff failed to document the results of flushing Resident #70's right ear. Resident #70's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/25/22, was signed as completed on 12/7/22. Resident #70 was assessed as able to make self understood and as able to understand others. Resident #70 was assessed to not have the Brief Interview for Mental Status completed due to the resident being "rarely/never understood." Resident #70 was assessed as being independent with transfers, dressing, and toilet use. The following information was found in a facility document titled "Ear Irrigation" (with a revised date of February 2018): "The following information should be recorded in the resident's medical record: 1. The date and time the ear was irrigated. 2. The name and title of the individual(s) who irrigated the ear. 3. The type of solution used to irrigate the ear. 4. All assessment data obtained concerning the resident's ear. 5. How the resident tolerated the procedure. 6. If the resident refused the treatment, the reason(s) why	F 842		

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 02/16/2023

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 842	Continued From page 56	F 842		

and the intervention taken. 7. The signature and title of the person recording the data." This Administrator provided the aforementioned document to the surveyor on 2/15/23 at 9:25 a.m.

Resident #70's medical provider orders included two (2) separate orders for the resident's right ear to be flushed after receiving ear wax removal drops. Documentation on Resident #70's medication administration record (MAR) included a nurse's initial indicating these orders were followed. Resident #70's clinical documentation failed to include details and/or results of the ear being flushed.

On 2/16/23 at 5:23 p.m., the survey team conducted a meeting with the facility's Administrator, Director of Nursing, and a Nurse Consultant. The surveyor discussed the failure of facility staff members to document details and/or results of flushing Resident #70's ear.

4. The facility staff failed to document admission notes for Resident #125.

Resident #125's Minimum Data Set (MDS) assessment had yet to be completed at the time of the survey.

The following information was found in a facility document titled "Admission Notes" (with a revised date of September 2021):
- "Preliminary resident information shall be documented upon a resident's admission to the facility."
- "When a resident is admitted to the nursing unit, the admitting Nurse must document the following information (as each may apply) in the nurses' notes, admission form, or other appropriate

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 02/16/2023

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 842	Continued From page 57 place, as designated by facility protocol: a. The date and time of the resident's admission; b. The resident's age, sex, race, and marital status; c. From where the resident was admitted (i.e., hospital, home, other facility); d. Reason for the admission; e. The admitting diagnosis; f. The general condition of the resident upon admission; g. The time the Attending Physician was notified of the resident's admission; h. The time the physician's orders were received and verified ..." Review of Resident #125's clinical record indicated the resident was admitted to the facility at least 38 hours prior to the documentation of the "Admission Data Collection" information. On 2/13/23 at 3:17 p.m., the surveyor interviewed the facility's Director of Nursing (DON) about Resident #125's admission documentation. The DON reported a progress note should have been written, for the time of the resident's arrival, to include: vital signs, how the resident arrived, general information about the resident, general condition of the resident, and the time of the resident's arrival. On 2/16/23 at 5:23 p.m., the survey team conducted a meeting with the facility's Administrator, Director of Nursing, and a Nurse Consultant. The surveyor discussed the failure of facility staff members to document Resident #125's admission assessment/information for the time of the resident's arrival. For Resident #176, facility staff failed to document reasons for not administering multiple medications and treatments.	F 842		

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 02/16/2023

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 842	Continued From page 58	F 842		

Based on facility document review and clinical record review, and staff interview facility staff failed to provide treatment as ordered for one of 24 current residents in the survey sample (Resident # 176).

Resident #176 was admitted to the facility on 2/9/2023. The resident's diagnoses included primary adrenocortical insufficiency, ploymeuropathy, chronic obstructive pulmonary disease, polymyalgia rheumatica, common variable immunodeficiency, morbid obesity type 2 diabetes mellitus, chronic pancreatitis, depression, anxiety, muscle spasms, nausea, allergies, edema, primary adrenocortical insufficiency, hypertension, and insomnia. At the time of the survey, the resident did not yet have a minimum data set assessment. The surveyor interviewed the resident on 2/13/2023 and found the resident knowledgeable about diagnoses and treatment and able to answer questions about the time in the facility. The resident expressed no concerns other than lack of medication availability and not having received a fentanyl patch (due every third day) since admission on 2/9.

The surveyor reviewed the clinical record on 2/13/2023 and discovered that fentanyl 75mcg transdermal patch apply 1 patch every 72 hours at 10 AM was ordered on admission on 2/9/23. Staff documented fentanyl N= not administered-other on 2/10 and 2/13/2023.

Review of the Medication Administration Record (MAR) on 2/15/2023 revealed the following additional medications documented as N=not administered without explanation on 2/12-2/14:

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 02/16/2023

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 842	Continued From page 59 2/12 8AM- Golytely, incruse ellipta 9AM- Gabapentin 9PM- methacarbamol 2/13 5AM- methacarbamol 8AM- Adair discus, Golytely 11AM- venlafaxine 8PM-topiramate, ursodiol, Lunesta 9 PM- methacarbamol 2/14 1AM- methacarbamol 5AM- methacarbamol 8AM-Golytely 12PM-diclofenac gel 6PM-diclofenac gel 9PM-methacarbamol There was no evidence that the physician/physician surrogate had been notified of any of the medications not being administered. During a brief interview on 2/16/2023 at 9:40 AM, the nurse caring for the resident, Licensed Practical Nurse (LPN) #5, stated that nurses were expected to document reasons for not administering ordered medications and treatments. During a summary meeting on 2/16/2023, the surveyor reported the medications that were documented as not administered without explanation.	F 842		