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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted on 11/12/2019 through 11/13/2019. One complaint, VA00047713 was investigated during the survey. This complaint was substantiated with related deficiencies cited. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 97 bed certified facility was 65 at the time of the survey. The survey sample consisted of three current resident reviews (Residents #2 through Resident #4) and one closed record review (Residents #1).	F 000		
F 558 SS=B	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on complaint investigation and group interview, the facility staff failed to place meal trays within the reach of two of 10 residents in the group interview, Resident #6 and #7. The two residents, both of whom eat their meals while in bed, stated that staff place the trays on their over bed tables, and out of their reach. The findings were: During the Group Interview at 1:30 p.m. on 11/12/19, which was attended by 10 alert and	F 558	The Carrington (_Facility_) is filing this plan of correction for the purpose of regulatory compliance. The Facility is submitting this plan of correction to comply with the applicable law. The submission of this plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiencies. See Plan of Correction for F558 See Plan of Correction for F689	12/11/19

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

Electronically Signed | 12/04/2019

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F 558	Continued From page 1 oriented residents, the subject of meal service was discussed. Asked where they ate their meals, seven of the residents said they eat all their meals in the Dining Room. The other three residents said they prefer to take their meals in their room. Asked about the delivery of the meals trays to their rooms, Resident #7 said, "They bring the tray in and put it on the (overbed) table and walk out. I'm too low in bed. I can't see the food." Resident #6 said, "They just leave the tray. They don't raise me up so I can see the food to eat." Both residents indicated that by the time the staff come back to position them so they can see to eat, the food is cold, but both also stated that staff will reheat the tray for them. Both Resident #7 and #6 were coded on their most recent MDS (minimum data set) as requiring set-up help with meals. Resident #10 stated that staff leave the meal tray on her (overbed) table, but she is able to get out of bed, move to a chair in her room, and pull the (overbed) table to her so she can eat. During a meeting at 11:40 a.m. on 11/13/19, the survey team discussed the findings with the Administrator, Director of Nursing, Assistant Director of Nursing, and one of the Unit Managers. COMPLAINT DEFICIENCY	F 558	A. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: 1. Resident #6 and #7 will be provided meal service and setup as required for their dining experience. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: 1. All residents receiving meal trays delivered in their rooms could have the potential to be affected by this deficient practice. C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: 1. Certified Nursing Assistants will be in-serviced in the correct procedures for delivery and setup of meal trays to the resident□s rooms. D. Monitoring of corrective action to ensure the deficient practice will not reoccur: 1. Director of Nursing or designee will audit the meal delivery and setup of ten room tray deliveries business daily for one month then monthly for two months for the correct procedures of food tray delivery and setup. Findings will be reported to the Nursing Home Administrator (NHA)	

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F 558	Continued From page 2	F 558	immediately when policy is not adhered to. 2. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy 3. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on complaint investigation, clinical record review, staff interview, and facility document review, the facility failed to ensure that two of four residents in the survey sample (Residents # 2 and 3) were free of accidents that resulted in harm; AND, failed to ensure that four of seven interviewed facility staff were knowledgeable about the facility's door alarm system. Residents # 2 and 3 suffered falls which resulted in	F 689	A. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: 1. Resident #2 will be provided a larger bed frame and be made a two person assist. 2. Resident #3 has been provided a wanderguard.	12/11/19

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F 689	Continued From page 3 fractures. Four of seven staff members were unable to explain or correctly identify the correlation between exit doors and the corresponding lights on each of the facility's two door alarm panels. The findings include: 1. Resident # 2 was admitted to the facility on 7/3/19, and most recently readmitted on 8/1/19 with diagnoses that included congestive heart failure, Non-Alzheimer's dementia, anxiety disorder, depression, morbid obesity, contractures of the left and right feet, and fracture of the left humerus. According to the most recent Minimum Data Set, a Quarterly review with an Assessment Reference Date of 10/10/19, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 08 out of 15. Under Section G (Functional Status), the resident was assessed as totally dependent with two persons physical assist for transfer; as totally dependent with one person physical assist for locomotion on and off the nursing unit, hygiene, and bathing; as needing extensive assistance with one person physical assist for bed mobility and dressing; and as independent with set-up help only for eating. Review of Resident # 2's hard copy clinical record revealed the following Nurses Notes: 7/19/19 - 8:30 p.m. "Resident was in bed, rolled out of bed on to floor face forward. Resident head on floor. Nose bleeding. Resident c/o (complained of) excruciating pain in left arm.	F 689	3. Staff will be trained in the facility door alarm system. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: 1. All residents with cognitive decline and all residents who are dependent for bed mobility could have the potential to be affected by deficient practice. C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: 1. Residents will be assessed for bed mobility. All resident dependent for bed mobility will be care planned for two persons assist of care delivery. 2. Certified Nursing Assistants will be in-serviced in Resident safety and turning positioning procedures. 3. All staff will be in-serviced on the facility door alarm system. D. Monitoring of corrective action to ensure the deficient practice will not reoccur: 1. Director of Nursing or designee will audit the four Certified Nursing Assistants while they perform proper turning and positioning 5 days per week for one month and then weekly for two months. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to.	

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F 689	Continued From page 4 Resident requested to go to hospital for medical care. 911 called." 7/20/19 - 3:00 a.m. "Resident returned to facility via transport. Alert & verbal. Diagnosis from hospital is L (Left) humerus fracture, skin tear of upper extremity. Humerus has been placed in sling and skin tear was dressed at the hospital...." 7/20/19 - 7:00 a.m. "CNA (Certified Nursing Assistant) stated that wheels on bed were broken and bed was not locked when she was changing resident. She went to get wipes and the bed rolled and the resident fell out of bed." A witness statement from the LPN (Licensed Practical Nurse) on duty at the time noted the following, "CNA called me to room where resident was laying face down on the floor. CNA stated that resident rolled out of bed while she was changing her. Resident head (with) lump above right eye and complained of severe pain. EMS called to pick resident up for evaluation." A witness statement from CNA # 4, who was attending to Resident # 2, noted the following, "I was changing resident, from one side to the other, as I was getting wipes the bed moved and the resident rolled on to the floor, I set (sic) with her until rescue came." At 3:30 p.m. on 11/12/19, CNA # 4 was interviewed and was asked to explain what happened on the night the resident fell. CNA # 4 said the resident needs two persons to transfer, but only one when changing briefs. She went on to say that she had rolled the resident over and was reaching for some wipes when the resident reached out and pushed on the nightstand next to	F 689	2. Doors will be checked daily for correct numbering to panel and door for two weeks. Diagram will be checked daily for placement for two weeks. Four staff will be tested daily for two weeks in knowledge of door alarm system. After two weeks testing will occur monthly for two months. All new employees will be oriented to the door alarm system. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to 3. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy 4. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan.	

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her bed. "I think she was trying to help me, but when she pushed on the nightstand, the bed moved and she rolled out of it," CNA # 4 said. Asked how often she provided care for Resident # 2, she said that night was the first time she had cared for her.

At 12 noon on 11/12/19, the Maintenance Director was interviewed regarding the brakes on resident beds. "If the brakes are broken on these old beds," the Maintenance Director said, "I just put a screw in the caster (wheel) to keep it from turning." Asked how he documents requests to repair the brakes on resident beds, and if the broken brakes on Resident # 2's bed were reported to him, the Maintenance Director said, "I keep a log and a journal. Some times it's just a verbal request."

At 12:10 p.m. on 11/12/19, the Maintenance Director returned with his log book and journal. According to the log book, the brakes on Resident # 2's bed were reported as broken on 7/14/19, and according to the journal, the brakes were repaired on 7/15/19. The Maintenance Director indicated he repaired the brakes by putting a screw in the caster.

Review of the facility's Incident/Accident Report, dated 7/19/19, noted the following under the item Steps Taken to Prevent Recurrence: "Need locks on wheels of bed. Educate staff with two person assist."

At approximately 10:30 a.m. on 11/13/19, observation of Resident # 2's bed found it to be on four legs without casters in place. When the Director of Nursing (DON) was asked if she knew when the resident received a new bed, she said

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she did not know but would check with maintenance. At approximately 10:50 a.m. on 11/13/19, the DON reported back that according to the Maintenance Director, Resident # 2's bed was replaced on 7/19/19.

During a meeting at 11:40 a.m. on 11/13/19, the survey team discussed the findings with the Administrator, Director of Nursing, Assistant Director of Nursing, and one of the Unit Managers.

2. Resident # 3 was admitted to the facility 02/01/2016 with the following diagnoses, including but not limited to: Bipolar disorder, dementia, and anxiety.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 08/02/2019. Resident #3 was assessed as severely impaired with a cognitive summary score of "03".

On 11/12/2019 at approximately 11:30 a.m. Resident #3 was observed lying on her bed. She was asked if she had a recent fall. She stated, "Yes, can you get me some pop?" She was asked how she had fallen. She stated, "I was outside, can I have some pop?" Resident #3 was asked if she was with someone when she fell. She stated, "No...can I have some pop?"

The clinical record was reviewed beginning at approximately 11:40 a.m. Discharge instructions from a local emergency department dated 11/18/2019 were observed and contained the following: "Diagnosis: 1. Greater Trochanter fracture; 2: Fall; 3. Dementia...you were diagnosed today with a fall and fracture of the greater trochanter of your right hip. This is not a

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typical fracture and you need to use a walker when walking and you can bear weight as tolerated. You need to follow-up with the orthopedic team in 10 days to 2 weeks..."

The most recent fall risk evaluation was dated 05/03/2019 and assessed Resident #3 as a "HIGH RISK for potential falls" with a score of "17". A "Wandering and Elopement Risk Assessment" dated 05/13/2019 contained the following statement, "No wandering or exit seeking behavior."

The following documentation was observed in the progress notes:

"10/19/2019 01:22 [1:22 a.m.] Returned to facility from [hospital name] via stretcher...diagnosed with fall and fracture of greater trochanter of the right hip. WBAT [weight bearing as tolerated]....moans in pain with movement..."

"10/23/2019 14:59 [2:59 p.m.] Late entry for 10/17/2019 Time: 1630 [4:30 p.m.] Was alerted down hallway by other staff member. Upon going down hallway to outside door, pt [patient] was observed lying on left side, Pt was awake, talking. Pt was checked before moving her. Was brought in building in w/c [wheelchair]. Was stating that her leg was hurting, Pt was saying she wanted to go outside. Notified MD and order received to sent pt to ER for eval due to complaint of pain."

The care plan documented the following: "2/22/2018 Resident with potential for falls due to decreased safety awareness and use of psychotropic medications..." Interventions included but were not limited to: "Fall risk assessment updated quarterly, annually, and with

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any change in condition; Redirect her to her room as needed..." Additionally, "02/22/2018 Resident with hx [history] of inappropriate behaviors..." Interventions included but were not limited to: "Maintain door alarms per facility protocol... Problem: 02/22/2018 Resident wanders into other resident rooms...Inteventions: Keep room darkened as much as possible, assist resident back into bed, provide snacks redirection our of other resident rooms..."

At approximately 2:00 p.m. the door where Resident #3 exited the building was observed. The door was located at the end of the hallway. RN [registered nurse] #1 was in the hallway and was asked if the door had an alarm if opened. She stated, "Yes." She was asked if she knew anything about Resident #3's fall outside. She stated, "I wasn't over here when it happened....It's my understanding that the alarm on the door was working." A staff member at the nurse's station was alerted by RN #1 that the door was going to be opened. She then stated, "Go ahead and open it [name] will reset it at the nurse's station." The door was pushed open and a low toned alarm was heard.

An investigation regarding the accident was requested and received from the DON (director of nursing). The incident form documented: "...Resident was found outside of building. Door alarm had sounded before pt was found outside....Predisposing Situation Factors Ambulating without assist..."

LPN (licensed practical nurse) #1 had completed the incident report and had written the late entry regarding the fall. She was interviewed on 11/12/2019 at approximately 3:00 p.m. She was

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asked what had happened. She stated, "I had just come in and the alarm went off...we checked the doors and we didn't see anyone...I turned off the alarm and reset it...about 5 -10 minutes later [name of RN #1] came over to that side...we talked for a few minutes and then she walked down the hallway to leave. We heard her say, 'Oh my God'...the resident was laying outside...we ran down there and got her up and back inside with a wheelchair...she ended up going to the hospital and her hip was broken." LPN #1 was asked what she meant when she said reset the alarm. She stated, "There's a control panel at the nurse's station, when the alarm sounds we don't really know which door it is, we just have to run around and check them." She was asked if she or any of the other staff had walked all the way down the hallways and looked out the doors. She stated, "I didn't walk all the way to the doors, I don't know about anybody else." She was asked why they thought the alarm had gone off if they didn't see anyone outside. She stated, "I don't know." She was asked how Resident #3 had gotten down the hall and out the door without anyone seeing her. She stated, "I don't know."

RN #1 was interviewed on 11/12/2019 at approximately 4:45 p.m. about Resident #3's fall. She stated, "I was working on the other side [east wing] that day, but I am the unit manager on the west side. I always go over there and check on things before I leave for the day. When I got over there they told me that the alarm had gone off and they didn't know why. We talked about the weekend and then I started down the hall to leave...I was there maybe 5-10 minutes. I always walk down that hallway, turn to the left and then go out the door in the back. When I got down there I looked out the door, that's just my habit,

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and I saw [name of Resident #3] laying there out of my peripheral vision. I thought I'm not seeing this. I yelled for help and we got her up and brought her back inside in a wheelchair. She was sent out and came back with a broken hip." RN #1 was asked why they staff had not seen her when the alarm went off. She stated, "I don't know...I got a quick course from [name of staff] on how the alarms work and what number on the panel goes with what door, but I don't think all the doors are marked with numbers."

The above information was discussed during an end of the day meeting on 11/12/2019 with the DON and the administrator. The administrator stated, "I don't know why they don't know what number goes with what door, they disarm them when the funeral home comes to pick up a body." The DON was asked how the staff was educated on the alarm panels. She stated, "It is part of the facility tour. They should know that." The DON was asked how often the facility assessments regarding falls and wandering were completed. She stated, "They should be done quarterly." She was asked if she was aware that Resident #3's last assessments were done in May. She stated, "No, I wasn't."

3. On 11/13/2019 the maintenance director was at the nurse's station on the west wing. He was asked about the control panel for door alarms. He stated, "The doors are labeled and the number of the door is the number that lights up on the panel." He was asked if he trained new staff members on that. He stated, "No, my job is to test them every Wednesday." The door at the end of the hallway where Resident #3 exited was observed; the maintenance director stated, "That's door number 7." There was not a number

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on the door identifying what it's number was. The maintenance director stated, "We had those windows tinted, it may have come off then." He pointed down the 500 hallway and stated, "That's door number 8, the 400 hall is number 7 and the 600 hall is number 9." The 500 hallway door was observed and was labeled with the number 9. He stated, "Part of the tape may have come off I'll fix it." All exit doors in the facility were then inspected with the maintenance director. There was not a number on the door for the 200 hallway on the east wing. He stated, "It's suppose to be number 3." The maintenance director was asked how staff would know what door to go to if the alarm went off and the number on the panel didn't coincide with the door. He stated, "They should know what they are...it would make sense to me that the doors were numbered the same as the hallway, but that's not how it is."

A total of seven staff members (including LPN #1 who was interviewed on 11/12/2019) were interviewed regarding the door alarms. Four of the seven staff members did not know how the alarms coincided with the facility doors. CNA (Certified nursing assistant) #2 stated, "I don't know anything about that...I just know when the alarms sounds, one of the doors has been opened and I run around like crazy until we figure out what happened." CNA #3 stated, "I don't know the door numbers. When the alarm rings I just go and look." RN #3 stated, "Don't quote me but I think that door down there (pointing to the 400 hall door) is 7...no wait, it might be 8...I'm not sure...I just know that if the alarm sounds and I don't know then I can go to the diagram next to the control panel and look at that." RN #3 went to the nurse's station and looked at the diagram that was divided into Zones. She stated, "Wait a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495302	A. BUILDING _____ B. WING _____	C 11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARRINGTON	2406 ATHERHOLT ROAD LYNCHBURG, VA 24501

(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
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minute, I am wrong...they don't coincide...I don't know."

RN #1 was interviewed on 11/13/2019 at approximately 9:00 a.m., regarding the location of Resident #3 when she was found outside. She walked down the hallway and pointed, "She was at the end of that railing." RN #3 was asked if she thought Resident #3 could have been seen without staff coming all the way down the hallway to the door. She walked back up the hallway and turned around looking out the door and stated, "No, they would have had to walk all the way down to see her."

No further information was obtained prior to the exit conference on 11/13/2019.