

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495349	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Carrington Place at Wytheville - Birdmont Center		STREET ADDRESS, CITY, STATE, ZIP CODE 990 Holston Rd Wytheville, VA 24382	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 7. The facility staff failed to ensure Resident #90's insulin was ordered and/or administered to address the resident's diabetic needs.</p> <p>Resident #90's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/26/25, was signed as completed on 1/29/25. Resident #90 was assessed as usually able to make self understood and as usually able to understand others. Resident #90's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition.</p> <p>Resident #90's clinical documentation indicated the resident arrived at the facility on 1/22/25 at 4:10 p.m. A DIET REQUISITION FORM for the resident to receive a no salt added, CCHO diet was used to communicate the resident's dietary needs to the dietary department on 1/22/25. (A CCHO diet is a consistent or controlled carbohydrate diet ordered to help control blood sugar levels.)</p> <p>Resident #90's hospital Discharge summary, dated [DATE] at 12:19 p.m., indicated the resident was to continue receiving:</p> <ul style="list-style-type: none"> - Insulin Glargine 25 units via subcutaneous injection at bedtime, and - Insulin Human Lispro 10 units via subcutaneous injection before meals. <p>(Insulin Lispro is a fast-acting insulin that starts to work in approximately 15 minutes, peaks in approximately one (1) hour, and keeps working for two (2) to four (4) hours; Insulin Glargine is a long-acting insulin that reaches the blood stream several hours after injection and controls blood sugar levels for up to 24 hours.)</p> <p>Resident #90's medical provider orders included an order, dated 1/22/25 at 2:39 p.m., for Insulin Lispro 10 units to be administered via subcutaneous injection before meals for diabetes. This order was entered to begin on 1/23/25 at 8:00 a.m. Therefore, the Insulin Lispro was not ordered to be administered prior to Resident #90's evening meal on 1/22/25.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident #90's medical provider orders included an order, dated 1/22/25 at 2:39 p.m., for Insulin Glargine 25 units injected subcutaneously at bedtime for diabetes. This medication was ordered to be started on 1/22/25. Review of Resident #90's medication administration record did not have evidence of this medication being administered on the evening of 1/22/25. On 5/1/25 at 9:55 a.m., the Assistant Director of Nursing (ADON) acknowledged that no documentation was found to indicate Resident #90's bedtime insulin was administered as ordered; the ADON reported it was possible the medication was administered when it arrived from the pharmacy without the nurse documenting its administration.</p> <p>On 1/22/25 at 7:11 p.m., Resident #90's blood sugar was documented as 133.0 mg/dL.</p> <p>On 1/23/25 at 10:09 a.m., Resident #90's blood sugar level was documented as being greater than 600. The nurse practitioner (NP) was notified and gave orders for 10 units of Humalog Insulin to be administered and the resident's blood sugar rechecked in 45 minutes.</p> <p>Resident #90's MAR indicated the resident was administered another dose of Humalog Insulin 15 units via subcutaneous injection at approximately 11:00 p.m., on 1/23/25, due to a continued high blood sugar level.</p> <p>Resident #90's progress notes included an entry dated 1/23/25 at 12:05 p.m.; the resident's blood sugar level continued to read HI on the glucometer (the HI reading indicated the blood sugar was greater than 600). The NP gave an order for Resident #90 to be transferred to the emergency department for further evaluation.</p> <p>The following information was found in a facility policy titled Admission/readmission Orders (with a revised date of September 2017):</p> <ul style="list-style-type: none"> - Physicians shall provide appropriate admission and readmission orders. - Residents/patients will receive appropriate treatments and services starting upon admission. - Residents and patients will not suffer complications because of incomplete, inaccurate, or delayed admission orders. - admission and readmission orders will include: . Orders related to interventions, including medications . - Essential information for new admissions or readmissions should include at least the following: . Medications . <p>Resident #90's emergency department (ED) documentation for the 1/23/25 visit indicated, by the resident's arrival at the ED, his blood sugar level had decreased to 324. The resident was discharged from the ED back to the facility without further treatment.</p> <p>On 5/1/25 at 4:37 p.m., the survey team met with the facility's Administrator, Director of Nursing, and Administrator-in-Training (AIT). The surveyor discussed the failure of the facility staff to administer Resident #90's 1/22/25 bedtime insulin as ordered by the medical provider. The surveyor discussed the failure of the medical provider to order Resident #90's before meal insulin for the evening meal on 1/22/25.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 5/6/25 at 4:28 p.m., the survey team met with the facility's Administrator, Director of Nursing, and Administrator-in-Training (AIT). The surveyor discussed the failure of facility staff to provide insulin to address Resident #90's needs.</p> <p>11. For Resident #198, facility staff failed to administer Gabapentin (an anticonvulsant also used to treat neuropathic pain) per provider order.</p> <p>Resident #198's diagnoses included but were not limited to chronic obstructive pyelonephritis. Section C (cognitive patterns) of the minimum data set with an assessment reference date of 04/15/25 coded the resident's brief interview for mental status a 15 out of 15 indicating the resident's cognition was intact.</p> <p>The resident's clinical record contained an order for Gabapentin 300mg, give one (1) capsule by mouth at bedtime for pain to start on 04/11/25. Resident #198's medication administration record (MAR) for April 2025 indicated facility staff documented a 9 on 04/11/25 and 04/13/25 for the Gabapentin medication. The MAR contained chart codes which read that 9 indicated Other/See progress notes. The progress note for the 04/11/25 dose read, New admit awaiting delivery from pharmacy. The progress note for the 04/13/25 dose read, Medication not available from pharmacy. The MAR documentation indicated the 04/12/25 dose was administered.</p> <p>On 05/02/25, the assistant director of nursing (ADON) provided the Cubex Inventory which listed Gabapentin 300mg capsule as available in the Cubex (backup medication dispensing system).</p> <p>On 05/06/25 at 11:54 a.m., the director of nursing (DON) was interviewed. The DON stated her expectation would be for facility staff to retrieve the Gabapentin 300mg capsule from the Cubex on both 04/11/25 and 04/13/25.</p> <p>During an end of day summary meeting with the administrator, DON, and administrator-in-training on 05/06/25 at 4:28 p.m., the issue regarding Resident #198 not receiving Gabapentin on two of three days though the medication was available in the Cubex was discussed. On 05/07/25 at 10:01 a.m., the DON reported speaking with the pharmacy about Resident #198's Gabapentin order. The DON stated the conversation with pharmacy did not change the fact the resident had a Gabapentin order to receive the medication and Resident #198 did not receive it on 04/11/25 or 04/13/25. The documentation showed the resident did receive the medication on 04/12/25 and the order was discontinued on 04/14/25.</p> <p>No further information was provided prior to the exit conference.</p> <p>8. For Resident #51 the facility staff failed to obtain daily weights per the physician's orders.</p> <p>Resident #51's clinical record listed diagnoses which included but not limited to chronic respiratory failure with hypoxia, morbid obesity, and obstructive sleep apnea.</p> <p>Resident #51's most recent minimum data set (MDS) with an assessment reference date of 02/28/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. this indicates that the resident is cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident #51's clinical record was reviewed and contained a physician's order summary which h read in part, Daily wt. (weight): report to MD a gain of 3 or more pounds overnight every day shift for CHF-start date 12/26/2025 and Tiotropium Bromide Monohydrate Inhalation Aerosol Solution 2.5 MCG/ACT (micrograms/activation) (Tiotropium Bromide Monohydrate) 2 puff inhale orally one time a day for COPD (chronic obstructive pulmonary disease)-start date 04/08/2025.</p> <p>Resident #51's electronic medication administration record for the months of January, February, March and April 2025 were reviewed and contained entries as above. The entry for daily weights was initiated as being done every day in January, but there was no area on the eMAR to document the weight. Daily weights for February documented 3 refusals on the eMAR, all other days initialed as being done, but no area on the eMAR to document weights. Daily weights for the month of March documented 6 refusals on the eMAR, all other days initialed as being done, but no area on the eMAR to document weights. Daily weights for the month of April documented 9 refusals on the eMAR, all other days initialed as being completed, except 04/23/25. There was no area on the eMAR to document weights until 04/16/25.</p> <p>Resident #51's nurse's progress notes were reviewed and contained notes which read in part, 2/19/2025 14:11 Daily wt: report to MD a gain of 3 or more pounds overnight every day shift for CHF (congestive heart failure). Resident refused wt today. This nurse and fellow Nurse on shift verified refusal, 02/20/2025 16:27 Daily wt: report to MD a gain of 3 or more pounds overnight every day shift for CHF. Resident refused wt today., 2/28/2025 18:13 Daily wt: report to MD a gain of 3 or more pounds overnight every day shift for CHF, 3/05/2025 18:19 Daily wt: .Despite multiple attempts resident continues to refuse to allow staff to obtain weight, 03/10/2025 13:47 Daily wt: .Resident refused to get up for wt today, 3/11/2025 17:50 Daily wt: report to MD a gain of 3 or more pounds overnight every day shift for CHF, 3/15/2025 15:24 Daily wt: report to MD a gain of 3 or more pounds overnight every day shift for CHF, 3/16/2025 09:58 Daily wt: .refused, 3/20/2025 17:54 Daily wt: .Refused despite multiple attempts throughout shift, 3/20/2025 14:16 Daily wt: refused, 4/6/2025 12:19 Daily wt: .refused risk v benefit education provided, 4/17/2025 18:58 Daily wt: .no weight done this shift, 4/19/2025 17:15 Daily wt: .resident refused, 4/21/2025 16:14 Daily wt: .refused x2 attempts, 4/22/2025 18:12 Daily wt: .Resident refused weight, states she does not feel like getting weighted today, 4/24/2025 19:22 Daily wt: .UAO (unable to obtain), 4/25/2025 16:59 Daily wt: report to MD a gain of 3 or more pounds overnight for CHF, 4/27/2025 18:04 Daily wt: .refused and 4/30/2025 Daily wt: .refused.</p> <p>Resident #51's weight record was reviewed and contained recorded weights on 01/01/25, 01/06/25, 01/08/25, 02/24/25, 03/14/25, 03/24/25, 04/16/25, 04/18/25, 04/20/25, 04/26/25, 04/28/25 and 04/29/25.</p> <p>Surveyor spoke with the director of nursing (DON) on 05/02/25 at 2:05 pm regarding Resident #51's daily weights. DON stated the link to enter weights on the eMAR was not active until 04/16 and that nurses were just signing off weights and not doing them.</p> <p>Surveyor requested and was provided with a facility policy entitled, Charting and Documentation which read in part, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial conditions, shall be documented in the resident's medical record . 2. The following information is to be documented in the resident medical record: c. Treatments and Services performed; d. Changes in the resident's condition.</p> <p>The concern of not obtaining resident's daily weights per the physician's order was discussed with the administrator, DON, and administrator-in-training on 05/06/25 at 4:30 pm.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>No further information was provided prior to exit.</p> <p>Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide care and/or services to address residents' needs for 11 of 30 sampled residents. Resident #26, #62, #4, #348, #15, #448, #90, #51, #65, #77, and #198.</p> <p>The survey team informed the facility on 5/05/25 at 4:05 PM of the Immediate Jeopardy situation regarding Resident #26, #62, #4, and #15 due to the facility staff failing to: (1) ensure timely laboratory test completion, (2) communicate abnormal results to the medical provider, (3) ensure a medical provider responded to abnormal laboratory results and/or (4) implement ordered treatments addressing abnormal laboratory results in a timely manner.</p> <p>The scope and severity were originally cited at a Level IV, pattern. On 5/06/25 at 3:45 PM, the Immediate Jeopardy was abated and lowered to a Level III, pattern.</p> <p>The findings included:</p> <p>1. For Resident #26, the facility staff failed to obtain a urinalysis with culture and sensitivity (UA C&S) as ordered by the medical provider, failed to obtain a CBC (complete blood count) and BMP (basic metabolic panel) laboratory testing in a timely manner, and failed to administer an antibiotic to treat a urinary tract infection (UTI) as ordered by the medical provider.</p> <p>Resident #26's diagnosis list indicated diagnoses, which included, but not limited to Acute Cerebrovascular Insufficiency, Diverticulitis of Intestine, and History of Urinary Tract Infections.</p> <p>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/26/25 assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 indicating the resident was severely cognitively impaired.</p> <p>Resident #26's comprehensive person-centered care plan included a focus area stating the resident had a history of urinary tract infections (UTIs).</p> <p>Resident #26 was seen by the nurse practitioner (NP) on 1/06/25, the progress note read in part .The patient is actively experiencing a burning sensation during urination and general discomfort. She has a documented history of recurrent UTIs .A urinalysis with culture and sensitivity will be ordered to confirm or rule out a urinary tract infection. If the test results confirm a UTI, appropriate antibiotics will be prescribed based on the sensitivity results .</p> <p>Surveyor reviewed Resident #26's clinical record and was unable to locate evidence of a UA C&S being obtained following the 1/06/25 provider note.</p> <p>On 5/01/25 at approximately 10:30 AM, surveyor spoke with Licensed Practical Nurse (LPN) #7 and requested results of the UA C&S ordered on 1/06/25. LPN #7 returned and confirmed there were no results and provided a copy of the 1/06/25 NP progress note with a handwritten note stating, no order entered by NP.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident #26 was seen by the NP on 1/28/25, the progress note read in part .The patient has experienced emesis over the past couple of days .She reports ongoing nausea and is having difficulty eating .Suspected dehydration is consistent with the patient's recent history of vomiting and difficulty eating. Lab orders for a BMP and CBC have been placed to further evaluate the patient's hydration status and overall health .</p> <p>The NP saw Resident #26 again the following day on 1/29/25. The progress note read in part .labs that were supposed to be drawn yesterday were not completed, but the staff has assured that they will be done today. The patient continues to exhibit signs of dehydration, and IV [intravenous] fluids are currently infusing .</p> <p>Resident #26's clinical record included results of the CBC and BMP indicating the labs were not collected until 1/30/25 at 6:00 AM. The results included a critically low hemoglobin of 5.8 (normal range 12-16) and a critically low hematocrit of 17.5 (normal range 37-47). The facility was notified of the critical lab values on 1/30/25 at 5:30 PM and Resident #26 was sent to an acute care hospital and admitted for treatment.</p> <p>A review of Resident #26's hospital Discharge summary dated [DATE] indicated the resident was admitted to the ICU (intensive care unit) for acute on chronic anemia, hypotension and volume depletion. Resident #26 received a total of four (4) units of packed red blood cells while hospitalized . While hospitalized a urinalysis was completed which was turbid in appearance with red blood cells too numerous to count, 5-10 white blood cells, many bacteria with some gross hematuria noted. The urine culture was positive for the bacteria Proteus Mirabilis, and she was treated with IV Rocephin (antibiotic). The discharge summary included instructions for the antibiotic, Ceftriaxone Sodium (Rocephin) 2 grams intravenous (IV) once daily for five (5) days.</p> <p>Upon readmission to the facility on 2/02/25, the antibiotic was transcribed incorrectly and entered as Ceftazidime 2 grams IV at bedtime for 5 days instead of Ceftriaxone Sodium (Rocephin) as ordered on the discharge summary.</p> <p>The NP saw Resident #26 on 2/07/25, the progress note read in part .The patient was recently diagnosed with a UTI and was supposed to start IV antibiotics per the discharge summary. However, the antibiotics were not initiated upon her return to the facility. This issue was discussed with the Director of Nursing (DON), Assistant Director of Nursing (ADON), and unit manager. The patient has hematuria .Initiated a discussion with the DON, ADON, and unit manager to ensure the patient's antibiotic treatment is started later today or in the morning .</p> <p>Resident #26 returned to the facility on 2/02/25 at approximately 5:00 PM and did not receive the first dose of IV antibiotics until 2/07/25 at bedtime. In addition to the delay in starting the IV antibiotics, the resident received five doses of Ceftazidime instead of Ceftriaxone Sodium. The resident never received Ceftriaxone Sodium.</p> <p>Surveyor spoke with the pharmacist on 5/01/25 at 11:49 AM regarding the delay in the antibiotic. The pharmacist stated the pharmacy received the order for IV Ceftazidime on 2/07/25 at 1:14 AM and the medication was delivered later the same day on 2/07/25. He also stated IV orders were not automatically sent to the pharmacy through the electronic medical record system.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 5/02/25 at 9:02 AM, surveyor spoke with the DON and asked if the facility had any additional information regarding the concerns identified with Resident #26. The DON responded by shaking her head no and stated she had no words for it.</p> <p>On 5/02/25 at 11:15 AM, surveyor spoke with the NP regarding the concerns identified with Resident #26's lab testing and antibiotic treatment. NP stated when she saw Resident #26 on 1/29/25 she expected to come in and have the lab results and stated the antibiotic on the discharge summary was just missed. NP stated at this point she has no concerns with the facility lab process but earlier when the lab was integrating with the electronic medical record system it was not integrating properly. NP stated she felt the identified problems occurred during the integration process. When asked her process for ensuring her orders and directives were carried out, she stated she assumed the staff do as they were directed.</p> <p>Surveyor received the facility policy titled Admission/readmission Orders which read in part .6. The physician will review all orders for accuracy and completeness .</p> <p>Surveyor also received the facility policy titled Lab and Diagnostic Test Results: Physician Role and Follow-Up which read in part Policy Statement 1. The facility shall use a systematic process for obtaining and reviewing lab and diagnostic test results and reporting results to physicians .</p> <p>On 5/05/25 at 4:05 PM, the survey team notified the Administrator and DON of the Immediate Jeopardy situation regarding Resident #26 and the facility's failure to obtain lab testing as ordered and in a timely manner and provide antibiotic treatment as ordered by the medical provider according to the discharge summary.</p> <p>On 5/05/25 at 6:12 PM, the Administrator presented the following immediate jeopardy abatement plan regarding Resident #26:</p> <ol style="list-style-type: none"> 1. Resident #26 medication was given in error on 2-7-25 with no adverse reaction MD notified and no new orders given on 5-5-2025 unable to correct any further. 2. Facility will audit 100% of residents currently residing in the facility back to 11-1-2024 to ensure that all MD/NP/Triage notes containing statements to order labs had a corresponding ordered lab with results. Any missed labs will be addressed with MD to get new orders and/or direction. 100% of ordered labs for residents currently residing in facility back to 11-1-2024 will be audited to ensure that the lab was obtained, notified to MD and received an intervention. 100% audit of all antibiotics since 11-1-2024 to ensure ordered antibiotic was the correct antibiotic administered. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/09/25 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired.</p> <p>Resident #62's comprehensive person-centered care plan included a focus area stating The resident has bladder/bowel incontinence. History of chronic UTIs [urinary tract infections] with an intervention for Labs per order.</p> <p>Resident #62 was seen by the nurse practitioner (NP) on 2/11/25, the progress note read in part .Patient is under the care of urology for the management of chronic recurrent urinary tract infections. Recent urinalysis indicates an active infection with greater than 100,000 organisms, suggesting a severe infection despite the current antibiotic regimen. Plan: The culture and sensitivity results have been requested to be faxed to the patient's urologist for further recommendations. The urologist will likely adjust the antibiotic regimen based on the sensitivity results to better target the causative organism .Patient's complaint of dysuria is consistent with the current urinary tract infection. This symptom is likely due to the irritation and inflammation caused by the infection .</p> <p>Surveyor reviewed Resident #62's clinical record and was unable to locate evidence of the urine culture and sensitivity results being sent to the urologist or evidence of treatment provided to address the identified urinary tract infection.</p> <p>On 4/30/25 at 11:51 AM, surveyor discussed the above concern with the Director of Nursing (DON). The DON stated the order to fax the UA C&S results to the urologist was never entered into Resident #62's clinical record. DON stated she has made the resident an appointment with the urologist for 5/15/25.</p> <p>On 5/02/25 at 11:26 AM, surveyor spoke with the NP who stated she remembered giving a verbal order to fax the UA C&S results to urology. NP stated she wanted this done because Resident #62 was on a daily antibiotic for UTI prophylaxis which was prescribed by the urologist and urology usually manages the resident's UTIs.</p> <p>Surveyor received the facility policy titled Verbal Orders which read in part .Policy Interpretation and Implementation .2. Verbal orders are those given by an authorized practitioner directly to a person authorized to receive and transcribe orders on his or her behalf .</p> <p>According to the clinical record, Resident #62 again complained of dysuria on 4/03/25. A 4/03/25 4:38 PM nursing progress note read in part Resident c/o [complaining of] dysuria; urine is cloudy and dark in color . MD notified, awaiting response. A new medical provider order was placed on 4/03/25 at 6:58 PM for a UA C&S.</p> <p>The urinalysis was completed on 4/04/25 resulting in a slightly cloudy appearance, 1+ protein, small amount of blood, large amount of leukocyte esterase, and positive for nitrites.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495349	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Carrington Place at Wytheville - Birdmont Center		STREET ADDRESS, CITY, STATE, ZIP CODE 990 Holston Rd Wytheville, VA 24382	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident #62 was seen by the physician on 4/07/25, the progress note read in part .The urinalysis results indicate the presence of nitrites and leukocyte esterase, which are suggestive of a urinary tract infection. However, the patient is currently asymptomatic, with no reported dysuria, suprapubic pain, or fever. This clinical picture is consistent with asymptomatic bacteriuria. Plan: At this time, the decision has been made to withhold empiric treatment for the UTI. The final culture results will be awaited to guide further management. If the culture results confirm a urinary tract infection, appropriate antibiotics will be initiated. The patient will be closely monitored for the development of any symptoms suggestive of a UTI .</p> <p>Surveyor reviewed Resident #62's clinical record and was unable to locate a culture and sensitivity report for the 4/04/25 urinalysis.</p> <p>On 4/30/25 at 3:25 PM, the DON confirmed there was no culture and sensitivity report for the 4/04/25 urinalysis. DON stated the nurse only checked UA and did not check culture and sensitivity on the lab requisition slip.</p> <p>On 5/01/25 at 4:34 PM, the survey team met with the Administrator, Administrator in Training, and the DON and discussed the concern of staff failing to send positive urinalysis results to the urologist for treatment and failing to obtain a culture and sensitivity resulting in an unaddressed positive urinalysis.</p> <p>A 5/01/25 6:24 PM nursing progress note read in part Resident discussed d/t [due to] received order 4/3 for UA C&S Urine was obtained not culture. New order received on 4/29/25 follow up with Urologist per NP progress note. Resident has Urology Appt May 15 2025 Resident continues on prophylactic Macrobid as ordered Dr. [name omitted] aware with new order obtain UA C&S this date .</p> <p>The urinalysis was performed on 5/01/25 with results revealing a small amount of blood, trace of protein, moderate amount of leukocyte esterase, 10-25 white blood cells and few bacteria with the culture report to follow.</p> <p>On 5/05/25 at 4:05 PM, the survey team notified the Administrator and DON of the Immediate Jeopardy situation regarding Resident #62 and the facility's failure to perform a urine culture and sensitivity (C&S) as ordered by the medical provider and failure to address positive urinalysis results on two separate occasions.</p> <p>On 5/05/25 at 6:12 PM, the Administrator presented the following immediate jeopardy abatement plan regarding Resident #62:</p> <ol style="list-style-type: none"> 1. Resident #62 new order UA C&S 5-1-2025, UA results with culture received 5-3-2025 antibiotic started 5-5-2025. The urology appointment is made or [sic] 5-15-2025. Consult from Urologist in 02-2024 stated return as needed, resident RP (responsible party) on 5-4-2025 reports chronic UTI and accepting to appointment. <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Carrington Place at Wytheville - Birdmont Center		STREET ADDRESS, CITY, STATE, ZIP CODE 990 Holston Rd Wytheville, VA 24382	
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>2. Facility will audit 100% of residents currently residing in the facility back to 11-1-2024 to ensure that all MD/NP/Triage notes containing statements to order labs had a corresponding ordered lab with results. Any missed labs will be addressed with MD to get new orders and/or direction. 100% of ordered labs for residents currently residing in facility back to 11-1-2024 [sic] be audited to ensure that the lab was obtained, notified to MD and received an intervention. 100% audit of all antibiotics since 11-1-2024 to ensure ordered antibiotic was the correct antibiotic administered.</p> <p>3. Educate 100% all Licensed Nurses on Lab process to ensure understanding and follow through on lab ordering, processing, receiving, and notification. Education on following transcribed orders to ensure appropriate antibiotics administration per physician orders. Education to Clinical managers to ensure they are following the CMM (clinical morning meeting) Process. NP to be educated by the Medical Director on ensuring transcription of notes placed with mention of orders, that orders are placed timely, results of orders are reviewed timely, and interventions are implemented timely based of [sic] lab findings. Facility MD to be educated by the [name omitted] Medical Director on ensuring transcription of notes placed with mention of orders, that orders are placed timely, results of orders are reviewed timely, and interventions are implemented timely based of [sic] lab findings. CMM will review triage notes to find mention of orders needed and following due process to track in Accordance [sic] to step four audits. Education to Infection Control Nurse in regards tracking [sic], monitoring, and documenting once Antibiotic order placed as resulting intervention of labs. Education of all new hire Licensed Nurses on Lab and Antibiotic process will be done on orientation.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure sufficient licensed nursing staff to provide services to assure residents attain or maintain the highest practicable physical wellbeing of each resident.</p> <p>The findings included:</p> <p>The facility failed to ensure the Director of Nursing (DON) and/or Licensed Nurse Unit Managers (UMs) had the required time to monitor and/or maintain the facility lab process.</p> <p>According to the current Facility assessment dated [DATE], the average daily census for this 107 certified bed facility was 98.</p> <p>According to the Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Reports, the facility had a one-star staffing rating for the previous four (4) quarters.</p> <p>During the survey, the survey team identified concerns for four (4) residents regarding the staff's failure to (1) ensure timely laboratory test completion, (2) communicate abnormal test results to the medical provider, (3) ensure medical provider response to abnormal test results, and/or (4) ensure orders were implemented addressing abnormal results in a timely manner. Due to this, the survey team identified an immediate jeopardy situation on 5/05/25 at 4:05 PM.</p> <p>On 5/02/25 at 1:06 PM, surveyor spoke with the DON regarding staffing and the DON stated the facility staffing goal for licensed nurses was four on each shift, however they averaged two to three nurses on night shift. DON stated they used the services of two staffing agencies and when needed she and/or the UMs cover and work the floor. When asked if she felt the concerns identified during the survey were related to staffing, the DON stated if she or the Unit Managers were on a cart it was hard to keep up with the facility processes.</p> <p>Surveyor requested and received the dates of when the DON served as a nurse or CNA (certified nursing assistant) since 1/01/25. According to the provided report, the DON worked as a floor nurse nine (9) days and as a CNA five (5) days from 1/01/25 through 4/30/25.</p> <p>On 5/05/25 at 1:22 PM, surveyor spoke with the Administrator who stated having the DON work on the floor was always a last resort. Surveyor asked the Administrator what he felt contributed to the identified lab concerns and he replied them (DON and UMs) being on the floor as much as they have been.</p> <p>No further information regarding this concern was presented to the survey team prior to the exit conference on 5/07/25.</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>Based on staff interview and facility document review, the facility staff failed to ensure professional staff had a valid license to practice in accordance with applicable state laws for 1 of 6 sampled licensed nurses, Licensed Practical Nurse (LPN) #12.</p> <p>The findings included:</p> <p>For LPN #12, the facility staff failed to ensure the nurse had a valid LPN license to practice in the Commonwealth of Virginia.</p> <p>LPN #12 was no longer employed at the facility.</p> <p>On 4/30/25, surveyor requested and received LPN #12's employee file which indicated they were hired on 3/06/23. LPN #12's employee records included a [NAME] Virginia (WV) State Board of Examiners for Licensed Practical Nurses Primary Source License Verification Report dated 3/06/23 at 10:26 AM indicating LPN #12 had an active WV Single State LPN license with an expiration date of 6/30/23. An undated, unsigned, handwritten note on the license verification report stated, applied for multi state lic. LPN #12's file also included an additional license verification report dated 4/27/23 also indicating the LPN had a single state WV LPN license.</p> <p>According to the National Council of State Boards of Nursing, Inc. (NCSBN) website, LPN #12 had no history of holding a Virginia LPN license.</p> <p>On 5/01/25 at 3:44 PM, surveyor spoke with a representative with the WV Board of Nursing who stated when someone lives in a non-compact state and desires to work in WV they must apply for and receive a WV Single State license.</p> <p>On 5/02/25 at 1:25 PM, surveyor spoke with the facility Human Resource Manager (HRM) who stated they were not employed at the time of LPN #12's hire. HRM stated LPN #12's employment dates were 3/06/23 through 12/31/23 with no breaks in employment.</p> <p>HRM described her current license verification process as prior to hire, she checks for a valid license, first checking the Virginia site and if needed she would check for a WV license. HRM stated the WV license must say multi-state and if it had single state the applicant would not be hired.</p> <p>On 5/05/25 at 1:22 PM, surveyor spoke with the Administrator who stated he became aware of LPN #12 having a WV single state license in January or February 2024 only after the LPN was no longer employed at the facility.</p> <p>Surveyor requested and received the facility policy titled Hiring which read in part .4. The following criteria will be considered in determining whether an applicant is qualified for a particular job position .c. Certifications and licenses .</p> <p>No further information regarding this concern was presented to the survey team prior to the exit conference on 5/07/25.</p>		