STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place at Wytheville - Birdmont Center	990 Holston Rd Wytheville, VA 24382

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to ensure 1 of 19 residents was assessed for self-administration of medications, Resident #119. The findings included:The facility staff failed to assess Resident #119 for self-administration of medications. Resident #119 had an Albuterol inhaler in their room. Resident #119's diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and heart failure. Section C (cognitive patterns) of Resident #119's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 07/19/25 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Indicating Resident #119 was cognitively intact. Resident #119's comprehensive care plan included the focus area has chronic obstructive pulmonary disease, chronic respiratory failure, and congestive heart failure. Interventions included give aerosol or bronchodilators as ordered. Resident #119's clinical record included a progress note dated 07/29/25 resident has albuterol inhaler in pocket, states he is keeping, not on med list. Also found OTC [over the counter] medications in a bag in side table drawer-colace and others unable to read, resident states '& you aren't taking them.'On 07/30/25 at 12:30 p.m., during an interview with Resident #119, Resident #119 was observed by the surveyor to put his hand in his pocket and pull out an inhaler. This resident stated he keeps his inhaler as he gets short of breath and had been on it a long time. The surveyor identified the name on the inhaler as being Albuterol. During a review of the clinical record the surveyor was unable to locate any evidence that this resident had been assessed for self-administration of medications. The clinical record included a provider order dated 07/15/25 for a Ventolin HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 4 hours as needed for dyspnea.The nursing staff had not documented on the medication administration record to indicate this medication had been administered for the month of July 2025.The facility policy titled, Self-Administration of Medications read in part, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party.On 07/30/25 at 3:45 p.m., during a meeting with the Administrator and Senior Administrator the issue with Resident #119 having medications at the bedside and no evidence of an assessment for self-administration of medications being identified by the surveyor was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interviews, clinical record reviews, and facility document review facility staff failed to implement a process that ensured all residents were provided written information concerning the right to formulate an advance directive for 11 of 30 sampled residents. (Resident #4, #39, #45, #62, #63, #65, #67, #77, #89, #198, #348). The findings were: The facility staff failed to ensure Residents #4, #39, #45, #62, #63, #65, #67, #77, #89, #198, and #348 were provided with written information on the right to accept or refuse medical or surgical treatment. The aforementioned residents' clinical records contained a document titled, ACKNOWLEDGMENT OF RECEIPT OF admission INFORMATION which residents or responsible parties signed upon admission. The document read in part, I acknowledge that I have received the following information at the time of my admission. I have had the following information orally explained to me by a representative of the facility. One of the over 20 items listed was titled, Advance Directive Handbook. On 04/30/25 at 9:35 a.m. when asked about the facility's process for assisting residents with advanced directives, the administrator reported they do not currently offer assistance to formulate an advanced directive. On 05/01/25 at 9:29 a.m., the administrator stated no Advanced Directive Handbook as referenced on the ACKNOWLEDGMENT OF RECEIPT OF ADMISSIONS INFORMATION exists and he could not find any evidence of advance directive education. On 05/01/25 at 4:37 p.m. during an end of day meeting with the administrator, administrator-in-training (AIT), and director of nursing (DON), the concern regarding residents formulating advance directives was shared. The facility's Advance Directive policy was provided and under Policy Interpretation and Implementation read in part, 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 2. Written information will include a description of the facility's policies to implement advance directives and applicable state law . 8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance . No further information was provided prior to the exit conference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review, and facility document review, the facility staff failed to notify the medical provider of a change in condition for 1 of 30 sampled residents (Resident #65). The findings included: For Resident #65 the facility staff failed to notify the medical provider of a change in condition that resulted in the resident being transferred to a higher level of care on 2/4/25. Resident #65's diagnosis list indicated diagnoses, which included, but not limited to, Heart Failure, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Respiratory Failure with Hypoxia, Atrial Fibrillation, Myocardial Infarction, Type 2 Diabetes Mellitus, Cardiomyopathy, Presence of Prosthetic Heart Valve, Presence of Cardiac Pacemaker, Transient Ischemic Attack, and Anxiety Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/14/25 assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of the clinical record disclosed a progress note dated 2/4/25 at 22:45 (10:45 PM) that read in part, . out to hospital . A review of a hospital Discharge summary dated [DATE] read in part, .was sent from local skilled nursing facility to emergency department on the evening of 2/4/25 with report of altered mental status .blood pressure was noted to be as low as 68/49 .was slightly tachycardic and tachypneic .recommended admission for stroke workup .patient was admitted under inpatient status to ICU (intensive care unit) . On 5/2/25 at 12:18 PM, the director of nursing informed the surveyor that she could not locate any evidence that the physician was notified of a change in condition or that the physician was notified of the transfer/discharge for Resident #65 on 2/4/25. This concern was discussed at the end of day meeting on 5/6/25 at 4:30 PM with the administrator, director of nursing, and administrator in training. Surveyor requested and received a facility policy titled, Change in a Resident's Condition or Status that read in part, .1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an) .d. significant change in the resident's physical/emotional/mental condition .g. need to transfer to a hospital/treatment center . No further information regarding this concern was presented to the survey team prior to exit on 5/7/25.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interviews and facility document review, the facility staff failed to provide a Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (ABN) notification for one (1) of three (3) residents selected for SNF Beneficiary Notification Review (Resident #100). The findings include: In the morning of 05/01/25, the administrator provided the requested list of Medicare beneficiaries who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months prior to the survey. Three (3) residents were selected for SNF Beneficiary Notification Review from the list. For Resident #100, the provided document read the resident was not provided the SNF ABN with the reason marked other and a hand-written explanation that read, I can't remember, I can't find in file. On 05/01/25 at 1:41 p.m., the surveyor spoke with the administrator who reported facility staff were unable to find any beneficiary documentation for Resident #100. During an end of day summary meeting on 05/01/25 at 4:37 p.m. with the administrator, administrator-in-training, and the director of nursing, the issue of Resident #100 not receiving the SNF ABN document was discussed. No further information was provided prior to the exit conference.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 3. The facility staff failed to notify the ombudsman of Resident #90's transfer/discharge to a local hospital. 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. Resident #90's clinical documentation indicated the resident was admitted to a local hospital on 1/26/25. No evidence was found by or provided to the surveyor to indicate the ombudsman had been notified of this discharge/transfer. The following information was found in a facility policy titled Transfer or Discharge, Preparing a Resident for (with a revised date of December 2016): The business office is responsible for: a. Informing appropriate departments of the resident's transfer or discharge; b. Informing the resident, or his or her representative (sponsor) of our facility's readmission appeal rights, bed-holding policies, etc.; and c. Others as appropriate or as necessary. 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; the surveyor discussed the absence of documentation to indicate the ombudsman had been notified of Resident #90's 1/26/25 discharge/transfer to the local hospital. 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 notify the ombudsman of Resident #90's aforementioned discharge/transfer. 4. For Resident #26, the facility staff failed to provide evidence of notification to the Office of the State Long-Term Care Ombudsman of the resident's unplanned discharge to an acute care hospital on 1/30/25. Resident #26's diagnosis list indicated diagnoses, which included, but not limited to Acute Cerebrovascular Insufficiency, Diverticulitis of Intestine, Anorexia Nervosa, History of Urinary Tract Infections, and Chronic Pain Syndrome. 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. Resident #26 was sent to an acute care hospital on 1/30/25. A nursing progress note dated 1/30/25 at 6:13 PM read in part .verbal order to send resident to the ED [emergency department]. Resident's needs cannot be met at this time due to critical lab values . Resident #26 was admitted to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/01/25 at 11:24 AM, surveyor spoke with the facility social worker (SW) and requested evidence of notification of discharge being provided to the Office of the State Long-Term Care Ombudsman regarding Resident #26. The SW stated she had not been notifying the State Long-Term Care Ombudsman of discharges and was unaware that she needed to do this. On 5/01/25 at 11:26 AM, surveyor notified the Administrator of the conversation with the SW, he stated he would check on this and speak with the SW. On 5/01/25 at 4:34 PM, the survey team met with the Administrator, Administrator in Training, and Director of Nursing and discussed the concern of the facility failing to provide discharge notifications to the State Long-Term Care Ombudsman's office. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/07/25. Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide written notification of the reason(s) for transfer and/or discharge to the resident and to the resident's representative(s) and/or failed to notify the ombudsman of the transfer and/or discharge for four (4) of thirty (30) sampled residents, (Resident #18, Resident #65, Resident #90, and Resident #26). The findings include: 1.For Resident #18, the facility staff failed to notify the office of the local long-term care ombudsman of a transfer/discharge to a higher level of care on 4/14/25. Resident #18's diagnosis list indicated diagnoses, which included, but not limited to, Hypertension, Adult Failure to Thrive, Dementia, Alzheimer's Disease, Anxiety Disorder, Depression, Atrial Fibrillation, and Chronic Kidney Disease-Stage 4. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/2/25 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of the clinical record indicated Resident #18 was transferred to the hospital on 4/14/25. No evidence of notification of the transfer/discharge being sent to the local long-term care ombudsman could be located. Surveyor requested evidence that the ombudsman was notified of the transfer/discharge that occurred on 4/14/25. On 5/1/25 at 11:24 AM, in an interview with other staff#1 (OS#1) when asked about ombudsman notification for resident discharges, she stated she hasn't been doing this and was unaware that she needed to be doing it. This concern was discussed at the end of day meeting on 5/6/25 at 4:30 PM with the administrator, director of nursing, and administrator in training. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to exit on 5/7/25. 2.For Resident #65, the facility staff failed to provide the resident and the resident's representative(s) written notice of the reason(s) for transfer/discharge to the hospital on 2/4/25 and failed to notify the office of the local long-term care ombudsman of the transfer/discharge. Resident #65's diagnosis list indicated diagnoses, which included, but not limited to, Heart Failure, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Respiratory Failure with Hypoxia, Atrial Fibrillation, Myocardial Infarction, Type 2 Diabetes Mellitus, Cardiomyopathy, Presence of Prosthetic Heart Valve, Presence of Cardiac Pacemaker, Transient Ischemic Attack, and Anxiety Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/14/25 assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of the clinical record indicated Resident #65 was transferred to the hospital on 2/4/25. No evidence of written notice of the reason for transfer/discharge being provided to the resident and the resident's representative could be located. Surveyor requested evidence of written notification for reason of transfer/discharge being provided to Resident #65 and the resident's representative and surveyor requested evidence the ombudsman was notified of the transfer/discharge that occurred on 2/4/25. On 5/1/25 at 11:24 AM, in an interview with other staff#1 (OS#1) when asked about ombudsman notification for resident discharges, she stated she hasn't been doing this and was unaware that she needed to be doing it. On 5/2/25 at 12:18 PM, the director of nursing (DON) informed surveyor she could not locate any evidence of the resident and the resident's representative receiving written notification of the reason for transfer/discharge. This concern was discussed at the end of day meeting on 5/6/25 at 4:30 PM with the administrator, director of nursing, and administrator in training. No further information regarding this concern was presented to the survey team prior to exit on 5/7/25.

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	495349	A. Building B. Wing	05/07/2025

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide and document sufficient preparation and orientation to the resident to ensure a safe and orderly transfer/discharge from the facility for (1) of (30) sampled residents, (Resident #65). The findings included: For Resident #65 the facility staff failed to provide and document sufficient preparation and orientation was provided to the resident in the clinical record to ensure a safe and orderly transfer/discharge to a higher level of care on 2/4/25. Resident #65's diagnosis list indicated diagnoses, which included, but not limited to, Heart Failure, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Respiratory Failure with Hypoxia, Atrial Fibrillation, Myocardial Infarction, Type 2 Diabetes Mellitus, Cardiomyopathy, Presence of Prosthetic Heart Valve, Presence of Cardiac Pacemaker, Transient Ischemic Attack, and Anxiety Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/14/25 assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of the clinical record disclosed a progress note dated 2/4/25 at 22:45 (10:45 PM) that read in part, . out to hospital . On 5/2/25 at 12:18 PM, the director of nursing (DON) informed surveyor she recalled when the resident was sent out. The family felt he had increased confusion and requested he be sent to the hospital. The nurse that did the discharge note did not document the discharge accurately. This concern was discussed at the end of day meeting on 5/6/25 at 4:30 PM with the administrator, director of nursing, and administrator in training. Surveyor requested and received a facility policy titled, Charting and Documentation that read in part, .All services provided to the resident .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 .regarding the resident's condition and response to care .2. The following information is to be documented in the resident's medical record .d. Changes in a resident's condition .7. Documentation of procedures and treatments will include care-specific details, including .c. The assessment data and/or any unusual findings obtained .f. Notification of family, physician or other staff as indicated . No further information regarding this concern was presented to the survey team prior to exit on 5/7/25.

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	495349	A. Building B. Wing	05/07/2025

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **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 provide residents and/or resident's representative with a facility bed hold policy upon transfer for one (1) of thirty (30) sampled residents, (Resident #65) The findings include: For Resident #65, the facility staff failed to provide the resident and/or the resident's representative with the facility bed-hold policy upon transfer/discharge to a higher level of care on 2/4/25. Resident #65's diagnosis list indicated diagnoses, which included, but not limited to, Heart Failure, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Respiratory Failure with Hypoxia, Atrial Fibrillation, Myocardial Infarction, Type 2 Diabetes Mellitus, Cardiomyopathy, Presence of Prosthetic Heart Valve, Presence of Cardiac Pacemaker, Transient Ischemic Attack, and Anxiety Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/14/25 assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of the clinical record indicated Resident #65 was transferred to the hospital on 2/4/25. No evidence of the facility's bed-hold policy being provided to the resident and/or the resident's representative could be located. On 5/2/25 at 12:18 PM, the director of nursing informed surveyor she could not locate any evidence indicating the bed hold was given to the resident and/or resident's representative for the discharge on [DATE]. This concern was discussed at the end of day meeting on 5/6/25 at 4:30 PM with the administrator, director of nursing, and administrator in training. No further information regarding this concern was presented to the survey team prior to exit on 5/7/25.

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	495349	A. Building B. Wing	05/07/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, staff interview, and clinical record review, the facility staff failed to ensure accurate minimum data set (MDS) assessments for one (1) of 30 sampled residents (Resident #59). The findings include: The facility staff failed to ensure that Resident #59's minimum data set (MDS) assessments correctly captured the resident's lower extremity functional range of motion. Resident #59's MDS assessment, with an Assessment Reference Date (ARD) of 2/19/25, was signed as completed on 2/20/25. Resident #59 was assessed as able to make self understood and as able to understand others. Resident #59's Brief Interview for Mental Status (BIMS) summary score was documented as a 00 out of 15; this indicated severe cognitive impairment. Resident #59's MDS assessment, with an ARD of 2/19/25, had the resident's functional limitation in range of motion assessed as both lower extremities having impairment. Resident #59's MDS assessment, with an ARD of 11/19/24, had the resident's functional limitation in range of motion assessed as both lower extremities having impairment. These two (2) assessments differed from other MDS assessments which had Resident #59 assessed as having no functional limitations in range of motion. On 5/1/25 at 2:15 p.m., the surveyor asked the Administrator-in-Training (AIT) for facility staff documentation addressing Resident #59's lower extremity functional range of motion decline which had been documented as part of the resident's MDS assessments. On 5/1/25 at 3:32 p.m., the Administrator reported the two (2) aforementioned MDS assessments are being modified to correct the resident's lower extremities functional range of motion assessments. These assessments were modified to indicate Resident #59 had no impairment with lower extremity functional range of motion. 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 Resident #59's two (2) MDS assessments which were modified due to the incorrect assessment of lower extremity functional range of motion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. Building B. Wing	05/07/2025

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on staff interviews, clinical record reviews, and facility document review, the facility staff failed to implement a process that ensured a baseline care plan was developed for every resident within 48 hours of admission and failed to provide the resident and their representative with a summary of that baseline care plan for 7 of 30 residents. (Resident #1, #32, #39, #65, #77, #89, and #348). The findings were: The facility staff failed to ensure a process was in place to provide residents and their representatives with a summary of the baseline care plan that was initiated within 48 hours of the resident's admission. The clinical record reviews failed to contain evidence Resident #1, #32, #39, #65, #77, #89, and #348 and their representatives were provided a baseline care plan. On 05/01/25 at 10:15 a.m., a surveyor spoke with the MDS (minimum data set) coordinator who stated MDS staff completed the baseline care plans in the computer following a resident's admission, but the coordinator had not been printing it out, providing a copy to the resident or reviewing it with the resident. On the same day at 2:10 p.m., another surveyor interviewed the MDS coordinator who stated she does not give baseline care plans to residents or families. The MDS coordinator stated, I start the comprehensive quick though, so they have a care plan within a week. When the surveyor stated the baseline care plan was to be completed within 48 hours and provided to the family, the MDS coordinator denied being aware of that requirement. The policy titled, Care Plans - Baseline was reviewed and under Policy Statement read, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. Under Policy Interpretation and Implementation the document read in part, 4. The resident and their representative will be provided a summary of the baseline care plan by completion of the comprehensive care plan that includes but is not limited to: a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary. During an end of day meeting on 05/01/25 at 4:37 p.m. with the administrator, administrator-in-training, and director of nursing (DON) the concern with baseline care plans not consistently being implemented within 48 hours of every resident's admission and the baseline care plan not being provided to the resident and representative was discussed. On 05/02/25 at 2:10 p.m. the DON reported not being able to find evidence of baseline care plans being provided to residents. No further information was provided prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place at Wytheville - Birdmont Center	990 Holston Rd Wytheville, VA 24382

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, resident interview, clinical record review and facility document review the facility staff failed to develop and implement a care plan for 2 of 30 residents, Resident #51 and Resident #77. The findings included: 1. For Resident #51 the facility staff failed to develop and implement a care plan for oxygen usage. Resident #51's clinical record listed diagnoses which included but not limited to chronic respiratory failure with hypoxia, morbid obesity, and obstructive sleep apnea. Resident #51's most recent minimum data set (MDS) with an assessment reference date of [DATE] 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. Section O, special treatments, procedures, and programs coded the resident as using oxygen while a resident. Resident #51's comprehensive care plan was reviewed, and surveyor could not locate a care plan related to oxygen usage. Resident #51's clinical record was reviewed and contained a physician's order summary which read in part, 02 via NC (nasal cannula) at 2L/min (liters/minute) via NC every day shift for 02 dropping and unable to breathe. Resident #51's electronic medication administration record for the month of [DATE] was reviewed and contained an entry as above. This entry was initialed as being completed per the physician's order. Surveyor observed Resident #51 on [DATE] at 10:35 am. Resident was resting on bed, 02 in place. Surveyor observed 02 concentrator set on 5 LPM (liters per minute). Surveyor observed Resident #51 on [DATE] at 10:00 am. Resident was resting on bed, eyes closed. 02 in place via NC. Surveyor observed 02 concentrator set on 5 LPM. Surveyor spoke with Resident #51 on [DATE] at 11:45 am regarding 02 usage. Resident #51 stated they are supposed to be on 5 LPM of oxygen. Surveyor spoke with the MDS coordinator on [DATE] at 2:00 pm regarding Resident #51. Surveyor asked MDS coordinator if oxygen usage for Resident #51 should be included in the comprehensive care plan, and MDS coordinator stated that care plan should be reflect oxygen usage. Surveyor requested and was provided with a 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. 7. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concern of not developing and implementing a care plan for oxygen was discussed with the administrator, director of nursing, and administrator-in-training on [DATE] at 4:35 pm. No further information was provided prior to exit. 2.For Resident #77, the facility staff failed to develop and implement a comprehensive person-centered care plan to identify potential triggers for the resident's diagnosis of post-traumatic stress disorder. Resident #77's diagnosis list indicated diagnoses, which included, but not limited to, Hemiplegia and Hemiparesis, Cerebral Infarction, Type 2 Diabetes Mellitus, Hypertensive Heart Disease, Depressive Episodes, Anxiety Disorder, Post-Traumatic Stress Disorder (PTSD), Suicidal Ideations, and Mood Affective Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of [DATE] assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of Section I (Active Diagnoses) was coded to indicate Resident #77 has Post-Traumatic Stress Disorder. Review of the comprehensive person-centered care plan disclosed a focus with an initiated date of [DATE], that read in part, .Reports PTSD of finding spouse in bed expired . No triggers were identified as part of the care plan interventions. On [DATE] at 9:55 AM, surveyor spoke with administrative staff #4 (AS#4) and asked about care planning and interventions for a resident with a diagnosis of PTSD. AS#4 stated if she knows and the symptoms are severe enough, she would put special engagements in place. She stated the IDT (interdisciplinary team) did not address or discuss Resident #77's PTSD while she was present in the care plan meeting. On [DATE] at 10:05 AM in an interview with the administrator, surveyor inquired what his expectation is for residents diagnosed with PTSD and he stated his expectation is for staff to properly assess them and discuss as a team. He agreed staff did not identify potential triggers for Resident #77 or put interventions into place. He stated staff needs education on trauma-informed care. This concern was discussed on [DATE] at 4:15 PM during the end of day meeting with the administrator, director of nursing and administrator in training. On [DATE], surveyor reviewed Resident #77's care plan again, and a focus with an initiated date of [DATE] read in part, .resident has dx (diagnosis) of PTSD she is at risk for nightmares, hallucinations which can be triggers to her PTSD . Review of the related interventions disclosed interventions that read in part, .be alert to any factors that could lead to an increase in triggers .be alert to any reports from resident of nightmares . (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received a facility policy titled, Care Plans, Comprehensive Person-Centered that read in part, .1. The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family .develops and implements a comprehensive person-centered care plan for each resident .2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .7. The comprehensive, person-centered care plan will .f. Incorporate risk factors associated with identified problems .8. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan as indicated .9. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process .10 .a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only the symptoms or triggers . No further information was provided to the survey team prior to exit on [DATE].

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	495349	A. Building B. Wing	05/07/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on staff interview, resident interview, clinical record review and facility document review, the facility staff failed to review and revise the comprehensive care plan for 2 of 30 residents, Resident #51, Resident #85. The findings included: 1. For Resident #51 the facility staff failed to review and revise the care plan for oxygen usage. Resident #51's clinical record listed diagnoses which included but not limited to chronic respiratory failure with hypoxia, morbid obesity, and obstructive sleep apnea. 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. Section O, special treatments, procedures, and programs coded the resident as using oxygen while a resident. It did not code the resident as using CPAP (continuous positive airway pressure). Resident #51's comprehensive care plan was reviewed, and contained a care plan for The resident is resistive to care r/t (related to) Dementia; refuses to wear CPAP, refuses meals at facility, refusing meds . Resident #51's physician's order summary was reviewed, and surveyor could not locate an order for CPAP use. Surveyor spoke with Resident #51 on 05/01/25 at 11:45 am regarding CPAP usage. Resident stated they had a sleep study way over a month or longer. Resident stated CPAP has come in, but I haven't been back to hospital to pick it up. I would have to spend the night again. Surveyor spoke with the MDS coordinator on 05/01/25 at 2:00 pm regarding Resident #51's CPAP. MDS coordinator stated that the resident did have a CPAP upon admission, but due to continued refusals, it was discontinued. Surveyor asked MDS coordinator if the care plan should have been updated to reflect that the resident no longer has a CPAP, and MDS coordinator stated that it should have been. Surveyor requested and was provided with a facility policy entitled Care Plans, Comprehensive Person-Centered which read in part, 7. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being; 14. The Interdisciplinary Team should review and update the care plan: b. When the desired outcome is not met; d. At least quarterly, in conjunction with the required quarterly MDS assessment. The concern of not reviewing and revising Resident #51's care plan was discussed with the administrator, director of nursing, and administrator-in-training on 05/01/25 at 4:35 pm. No further information was provided prior to exit. (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #85 the facility staff failed to review and revise the care plan for tube feeding. Resident #85's clinical record listed diagnoses which included but not limited to congestvie heart failure, diabetes mellitus type 2, and dysphagia. Resident #85's most recent minimum data set (MDS) with an assessment reference date of 03/20/25 assigned the resident a brief interview for mental status score of 7 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Section K, swallowing and nutritional status, coded the resident as having a feeding tube, receiving a mechanically altered diet, and receiving 51% or more of total calories throught parenteral feeding. Resident #85's comprehensive care plan was reviewed and contained a plan for Nutrition: The resident requires tube feeding r/t (related to) Dysphagia. Resident has history of vitamin deficiency, heart failure, gastrostomy malfunction, endentulous, receiving mechanically altered diet, at risk for weight loss. Interventions for this care plan include The resident is dependent with tube feeding and water flushes. Resident #85's clinical record was reviewed and contained a physician's order summary which read in part, Regular diet Puree texture, Nectar/Mildly Thick consistency, and Check PEG (percutaneous endoscopic gastrostomy) tube placement and flush with 100ml water daily for maintenance/patentcey .every day and night shift for tube. Surveyor spoke with the MDS coordinator on 05/01/25 at 2:15 pm regarding Resident #85's care plan. MDS coordinator stated that the care plan should have been updated to reflect that resident is no longer dependent on tube feedings. Surveyor requested and was provided with a facility policy entitled Care Plans, Comprehensive Person-Centered which read in part, 7. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being; 14. The Interdisciplinary Team should review and update the care plan: b. When the desired outcome is not met; d. At least quarterly, in conjunction with the required quarterly MDS assessment. The concern of not reviewing and revising Resident #85's care plan was discussed with the administrator, director of nursing, and administrator-in-training on 05/01/25 at 4:35 pm. No further information was provided prior to exit.

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	495349	A. Building B. Wing	05/07/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 3. The facility staff failed to follow professional standards of practice related to documenting the pronouncement of death for Resident #95. Resident #95's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/6/25, was signed as completed on 3/10/25. Resident #95 was assessed as usually able to make self understood and as usually able to understand others. Resident #95's Brief Interview for Mental Status (BIMS) summary score was documented as a 9 out of 15; this indicated moderate cognitive impairment. On the morning of 5/2/25, the following information was found in Resident #95's clinical record, as part of a licensed practical nurse's progress note dated 4/10/25 at 4:01 a.m.: Resident presents with no signs of life, no blood pressure, no pulse, no respirations. Resident is a DNR. Post mortem care provided by CNAs. DON notified and pronounced resident at 0351. (Resident #95 was not a hospice patient.) Documentation of a registered nurse's assessment for the pronouncement of death was not found. The following registered nurse progress note was documented on 5/2/25 at 11:01 a.m.: Late Entry: On 4/10/25 Hall nurse notified DON of resident expiring. DON assessed resident with no noted respirations no apical heart rate no obtainable blood pressure noted. DON RN pronounced resident at 0351 [sic]. On 5/2/25 at 10:44 a.m., the Administrator-in-Training (AIR) provided the surveyor with a copy of telephone information which showed the licensed practical nurse (LPN) telephoned the DON twice on 4/10/25 to have the DON come to the facility to pronounce Resident #95's death; these calls were timed at 2:21 a.m. and 2:49 a.m. Resident #95's clinical record did not include documentation of the LPN's assessment and/or findings which resulted in the need for the LPN to contact the DON to pronounce the resident's death. On 5/2/25 at 1:13 p.m., the Administrator reported being unable to find a facility policy to guide the pronouncement of a resident's death. The following information was found in a facility document titled Charting and Documentation (with a revised date of 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. - The following information is to be documented in the resident medical record: . Objective observations . Changes in the resident's condition . Events, incidents or accidents involving the resident . 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 follow professional standards of practice related to assessment and clinical documentation of Resident #95's pronouncement of death. (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For Resident #51 the facility staff documented medications as administered when the medication was not available, and documented daily weights as being obtained when they were not. Resident #51's clinical record listed diagnoses which included but not limited to chronic respiratory failure with hypoxia, morbid obesity, and obstructive sleep apnea. 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. Resident #51's comprehensive care plan was reviewed and contained plans for The resident has hypertension (HTN) r/t (related to) CHF (congestive heart failure). Interventions for this plan include Weight per order and Medication per order. 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. 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 initialed 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. 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. The entry for Tiotropium Bromide Monohydrate Inhalation Aerosol Solution 2.5 MCG/ACT (Tiotropium Bromide Monohydrate) 2 puff inhale orally one time a day for COPD (chronic obstructive pulmonary disease) was initialed as administered on 04/08/25, 04/11/25, 04/16/25, and 04/17/25. This entry was coded 9 on 04/09/25, 04/10/25, 04/12/25, 04/15/25 and coded 5 on 04/14/25 and 04/18/25. Chart codes 9 and 5 are equivalent to Other/See progress notes and Hold/See progress notes. Resident #51's nurses progress notes were reviewed and contained notes which read in part, 4/09/2025 17:23 Tiotropium Bromide Monohydrate Inhalation Aerosol Solution 2.5 MCG/ACT 2 puff inhale orally one time a day for COPD. Notified pharmacy of need, 4/10/2025 14:03 Tiotropium Bromide Monohydrate Inhalation Aerosol Solution .called pharmacy of need, 4/12/2025 14:58 Tiotropium Bromide Monohydrate . awaiting pharmacy, 4/13/2025 10:52 Tiotropium Bromide Monohydrate .awaiting pharmacy, 4/14/2025 13:20 Tiotropium Bromide Monohydrate .on hold til prior auth is completed and sent to pharmacy, 4/14/2025 Tiotropium Bromide Monohydrate .on hold til pre auth is complete, and 4/18/2025 15:00 Tiotropium Bromide Monohydrate .on hold til prior auth goes thru, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor spoke with the director of nursing (DON) on 05/02/25 at 2:05 pm regarding Resident #51's daily weights and inhaler orders. 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. DON stated that resident's inhaler was ordered on 04/08/25, but not received at the facility until 04/17/25, and that nurse's were signing, but not administering the medication. 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. Surveyor requested and was provided with a facility policy entitled Documentation of Medication Administration which read in part, the facility shall maintain a medication administration record to document all medications administered .2. Administration of medication must be documented immediately after (never before) it is given. The concern of not obtaining resident's daily weights per the physician's order and signing off on a medication that was not administered was discussed with the administrator, DON, and administrator-in-training on 05/06/25 at 4:30 pm. No further information was provided prior to exit. Based on staff interview, clinical record review and facility document review the facility staff failed to follow professional standards of practice for 3 of 30 residents in the survey sample, resident #448, #95, and #51. The findings included: 1. For resdent # 448 (R448) the facility staff failed to properly and promptly assess the resdent after a fall that resulted in a right hip fracture. R448's diagnoses included but were not limited to, nondisplaced fracture of the base of neck of right femur, chronic obstructive pulmonary disease, age related osteoporosis, Alzheimer's disease with late onset and anxiety disorder. R448's minimum data set (MDS) assessment with an assessment reference date of 2/23/24 assigned the resident a brief interview for mental status score of 0 indicating severe cognitive impairment. (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the clinical record, a progress note dated 1/15/24 at 10:12 PM read, On 1/14/24 at 1:00 AM the aide was doing rounds when he found resident in her bathroom floor, resident had fell on her right side. After getting resident up she wasn't able to bear weight on her right leg. She was placed in her wheelchair and brought out to the nurses station so neuros (neuro checks- a quick neurological assessment, used to monitor a patient's neurological status) could be started and she could be monitored. After an assessment of her body, a small skin tear was found on her right elbow; along with a skin tear to her right knee. Resident was alert to name and touch, her speech was clear. Residents vitals were elevated at this time. After continuing to monitor resident her right knee started to bruise. I then placed the o2sat monitor on residents finger as I assessed her right leg, when lifting the right leg the slightest, resident screamed out and grabbed at her hip. I then noticed her pulse rate had risen to 114. I immediately called the on-call phone, along with the on-call doctor. (Name omitted) gave me the instructions to send resident to the emergency room. I then attempted to contact the residents family, unfortunately no answer and no voicemail options available. On 5/5/25 at 3:45 PM this surveyor met with the Administrator to discuss this concern. This surveyor asked for any evidence they could provide of R448 being assessed prior to being moved out of the floor and anything as to how long the resident sat in the wheelchair at the nurses station prior to being sent out to the hospital. The Administrator stated that a fall investigation tool had been put into place prior to R448's fall and he would locate that document. The Administrator stated that the nurse working at the time of the fall was an agency nurse and was no longer assigned to the facility. The Administrator provided a falls policy upon request. On 5/6/25 8:10 AM this surveyor asked the Administrator if they had located any other documentation and they stated, I have nothing. This surveyor asked for any additional policies and asked if there is an Emergency Department note that might state what time R448 arrived there. The Administrator stated, I recognize this is an issue and we didn't do what should have been done. The same thing happened with this patient and this nurse a few days earlier than this incident and she (the nurse) did what she should have and documented the assessment and so she knew what was right. The Administrator admitted that the resident should have been assessed prior to being gotten up and should have been sent out immediately when it was noted that she could not bear weight. When asked for a standard of practice reference he stated, Your nursing education. I'll see if there is anything else in our policy but really as a nurse, it's basic nursing to assess the patient and not move them until you know there's no injury. They should have done a post fall assessment and there is nothing I can find to say that it was done. On 5/6/25 at 9:19 AM this surveyor interviewed Licensed Practical Nurse (LPN) #9. When asked what they should do if they enter a room and a resident is lying in the floor they stated. I need to check them for injury. Ask if they are hurting, make sure they can move everything before I get help to get them up. On 5/6/25 at 9:22 AM this surveyor interviewed LPN #10 about what to do when a resident falls. They stated, I need to see if they are hurt, call the doctor and the family. When asked if they are getting the resdent up they stated, Not if they are having any pain, not until we figure out if they have a fracture or a head injury. On 5/6/25 at 9:30 AM this surveyor interviewed LPN #6. They stated, I would check for any injuries, get their vital signs, their range of motion and everything. If I think they may have an injury I'm going to call the doctor, I'll have somebody else sit with them while I do that. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A document entitled, Emergency Department Record with an arrival date of 1/14/24 and a recorded time of 4:44 AM was provided and reviewed. The document read in part, .Per nursing home report, the patient fell at ground level about 1:00 AM this morning, since then has been back in a recliner . The document went on to read, Exam: 06:31 Constitutional: The patient appears alert, awake, frail, in obvious pain . According to the document R448 was diagnosed with a mildly displaced acute intertrochanteric fracture of the right femoral neck at 6:36 AM. The resident was then transferred to another hospital for surgical management of the fracture. The policy entitled, Falls Management was reviewed. Under the heading Purpose, the document read, The purpose of this procedure is to provide guidelines for identifying residents at risk for falls, evaluating a resident after a fall and to assist staff in identifying causes of the fall. Under the heading, Preparation the document read, Review the resident's care plan to assess for any special needs of the resident. Identify the resident's current medications and active medical conditions. Under the heading General Guidelines the document read, 1. Falling may be related to underlying clinical or medical conditions, overall functional decline, medication side effects, and/or environmental risk factors. 2. Resident's to be assessed upon admission and regularly afterward for potential risk of falls. 3. Document in the medical record. Under the heading, Reporting the document read, Notify the following individuals when a resident falls; a. The resident's family; b. The Attending Physician (timing of the notification may vary, depending on whether injury was involved); c. The Director of Nursing Services; and d. The Nursing Supervisor on duty. Report other information in accordance as defined by State and Federal Regulations and professional standards of practice. On 5/6/25 at 4:30 PM the survey team met with the Administrator, Director of Nursing and the Administrator in Training. This concern was reviewed with them at that time. No further information was provided to the survey team prior to the exit conference.

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	495349	A. Building B. Wing	05/07/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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. 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. 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.) Resident #90's hospital Discharge summary, dated [DATE] at 12:19 p.m., indicated the resident was to continue receiving: - Insulin Glargine 25 units via subcutaneous injection at bedtime, and - Insulin Human Lispro 10 units via subcutaneous injection before meals. (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.) 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. 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. On 1/22/25 at 7:11 p.m., Resident #90's blood sugar was documented as 133.0 mg/dL. 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. Building B. Wing	05/07/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 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. The following information was found in a facility policy titled Admission/readmission Orders (with a revised date of September 2017): - 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 . 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. 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. 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. 11. For Resident #198, facility staff failed to administer Gabapentin (an anticonvulsant also used to treat neuropathic pain) per provider order. 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. (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 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). 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. 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. No further information was provided prior to the exit conference. 8. For Resident #51 the facility staff failed to obtain daily weights per the physician's orders. Resident #51's clinical record listed diagnoses which included but not limited to chronic respiratory failure with hypoxia, morbid obesity, and obstructive sleep apnea. 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. 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. Building B. Wing	05/07/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 initialed 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. 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, 3/20/205 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. 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. 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. 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. 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. No further information was provided prior to exit. 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. (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 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. The findings included: 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. 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. 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. Resident #26's comprehensive person-centered care plan included a focus area stating the resident had a history of urinary tract infections (UTIs). 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 . 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. 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. 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 . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 . 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. 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. 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. 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 . 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. 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. 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. (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. Surveyor received the facility policy titled Admission/readmission Orders which read in part .6. The physician will review all orders for accuracy and completeness . 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 . 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. On 5/05/25 at 6:12 PM, the Administrator presented the following immediate jeopardy abatement plan regarding Resident #26: 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. (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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Carrington Place at Wytheville - Birdmont Center	990 Holston Rd Wytheville, VA 24382

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. Licensed Nurses with Agency will be educated using the Agency orientation binder on Lab and antibiotic process and that binder will be present at Pace nurses station for review. 4. Facility will audit orders daily through Clinical morning meetings to ensure notes of physicians are read, to ensure that orders are transcribed for processing. Facility will use CMM to ensure that the orders are collected and sent. Facility will use the CMM to track and follow the conclusion of the labs and that Physician notification was completed. A laboratory tracking log will be followed until intervention was put in place and/or no new orders obtained. 5. 5-06-2025 1414 [2:14 PM] 6. Executive Director [name omitted] On 5/05/25 at 6:20 PM, the survey team informed the Administrator that the facility's plan of correction (POC) was accepted. The facility presented credible evidence that the POC had been implemented, including evidence of nurse education as outlined in the POC. Interviews with the medical director, NP, and licensed nursing staff also verified education as outlined in the POC. On 5/06/25 at 3:45 PM, the survey team notified the Administrator that the immediate jeopardy was abated. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/07/25. 2. For Resident #62, the facility staff failed to perform a urine culture and sensitivity (C&S) lab test as ordered by the medical provider and failed to address positive urinalysis results on two separate occasions. Resident #62's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease and Atherosclerotic Heart Disease of Native Coronary Artery. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 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. 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 . 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. 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. 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. 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 . 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. 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 . Surveyor reviewed Resident #62's clinical record and was unable to locate a culture and sensitivity report for the 4/04/25 urinalysis. 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. 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. 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 . 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. 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. On 5/05/25 at 6:12 PM, the Administrator presented the following immediate jeopardy abatement plan regarding Resident #62: 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 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.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on staff interview, clinical record review, and facility document review, the facility staff failed to document tube feeding residuals for one (1) of 30 sampled residents (Resident #67). The findings include: The facility staff failed to document the amount when checking Resident #67's tube feeding residuals. Resident #67's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/13/25, was signed as completed on 3/14/25. Resident #67 was assessed as usually able to make self understood and as usually able to understand others. Resident #67's Brief Interview for Mental Status (BIMS) summary score was documented as a 10 out of 15; this indicated moderate cognitive impairment. Resident #67's clinical record included an order dated 8/13/24 at 1:17 p.m. for Enteral: Check gastric residual volume prior to feeding. Hold if >150 and notify MD. The Order Summary for this order included the following instructions: three times a day check gastric residuals: if greater than 150 hold and notify MD. (Enteral feeding is when an individual who is unable to eat or drink is provided nutrition via a tube into the gastrointestinal (GI) tract.) Resident #67's care plan included an intervention, dated 9/4/24, for staff members to [c]heck gastric residual volume prior to feeding. Resident #67's medication administration record (MAR) included an area to indicate that gastric residuals were completed three times a day. The April 2025 MAR indicated the facility staff consistently checked Resident #67's gastric residuals three times a day. The amount of gastric residuals was not found documented in Resident #67's clinical record. On 5/2/25 at 12:19 p.m., the Director of Nursing confirmed Resident #67's residual amounts were not being documented. The following information was found in a facility document titled Checking Gastric Residual Volume (GRV) (with a revised date of November 2018): The person performing this procedure should record the following information in the resident's medical record: . The amount, if any, of gastric residual. 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 the facility staff to document the amount of gastric residuals.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interview, resident interview, clinical record review and facility document review the facility staff failed to provide respiratory services per the physician's orders for 1 of 30 residents, Resident #51. The findings included: For Resident #51 the facility staff failed to provide oxygen per the physician's order. Resident #51's clinical record listed diagnoses which included but not limited to chronic respiratory failure with hypoxia, morbid obesity, and obstructive sleep apnea. 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. Section O, special treatments, procedures, and programs coded the resident as using oxygen while a resident. Resident #51's clinical record was reviewed and contained a physician's order summary which read in part, 02 via NC (nasal cannula) at 2L/min (liters per minute) via NC every day shift for 02 dropping and unable to breathe. Resident #51's electronic medication administration record for the month of April 2025 was reviewed and contained and entry as above. This entry was initialed as administered as ordered each day. Surveyor observed Resident #51 on 04/30/25 at 10:30 am. Resident was resting in bed, 02 in place via nasal cannula. Surveyor observed 02 concentrator set at 5 LPM (liters per minute). Surveyor observed Resident #51 on 05/01/25 at 10:00 am. Resident was resting in bed, 02 in place via nasal cannula, with oxygen concentrator set on 5 LPM. Surveyor spoke with Resident #51 on 05/01/25 at 11:45. Resident stated that 02 is supposed to be at 5 LPM. Surveyor spoke with director of nursing on 05/01/25 at 4:30 pm regarding Resident #51's oxygen order, and surveyor's observations. Resident #51's nurse's progress notes were reviewed and contained notes which read in part, 5/1/2025 16:31 Spoke no NP (nurse practitioner) regarding resident's 02 order. New order obtained for 02 @ 5L/min via NC. Concentrator setting verified and 5/1/2025 20:32 Resident was discussed with IDT (interdisciplinary team) this shift d/t (due to) resident's 02 order. Clarification received per . MD d/t resident oxygen saturation level of 91 % on 2L/min via nasal cannula, new order received 02 via nasal cannula @5l/min. Oxygen concentrator adjusted to 5L at this time and oxygen saturation reobtained and 94% on 5L/min via nasal cannula, resident experiences dyspnea on exertion . Surveyor requested and was provided with a facility policy entitled Oxygen Administration which read in part, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 3. The rate of oxygen flow, route, and rationale. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor spoke with the director of nursing on 05/05/25, and director of nursing reported that Resident #51's oxygen order had been changed to 5 LPM by the physician. The concern of not following the physician's order for the administration of oxygen was discussed withthe administrator, director of nursing and administration-in-training on 05/06/25 at 4:30 pm. No further information was provided prior to exit.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **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 that pain management is provided to residents consistent with professional standards of practice and the person-centered comprehensive care plan for 1 (one) of 30 residents in the survey sample, resident #448 (R448). The findings included: R448's diagnoses included but were not limited to, right hip fracture post-surgical repair, Alzheimer's Disease, chronic obstructive pulmonary disease, osteoporosis, osteoarthritis, pain unspecified and restless leg syndrome. The minimum data set (MDS) assessment with an assessment reference date of 1/24/24 assigned the resident a brief interview for mental status (BIMS) score of 1 out of 15, indicating severe cognitive impairment. Under Section D- Mood, R448 was coded as feeling down, depressed or hopeless 7-11 days in the last two weeks, having little pleasure in doing things 7-11 days in the last two weeks, trouble falling or staying asleep 7-11 days in the last two weeks and feeling tired or having little energy 7-11 days in the last two weeks. R448 was coded as requiring moderate to maximal assistance for bed mobility and transfers. The resident was coded as having pain frequently over the last 5 days and was unable to answer if the pain had interfered with sleep. Over the last five days of the look back period, the resident reported a pain level as high as a 6 on a 1-10 scale. The comprehensive care plan was reviewed. A focus for pain was noted with interventions that included, Reposition for comfort as needed and Notify physician of unrelieved pain and or ineffective pain management. The provider's notes were reviewed. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The progress notes were reviewed. On 1/23/25 at 2:40 PM a note read, (name omitted) has a fx'd (fractured) hip and is having pain, she has pain meds, today is the first day that she has been up with therapy. A note dated 2/5/24 at 12:15 AM read, Resident continues to yell out and appears to be in pain even after receiving PRN (as needed) pain narcotic pain medication. A note dated 2/17/25 at 6:55 PM read, Shouting out for help with c/o (complaints of) pain in legs even after PRN Norco administered. Will put on dr. rounding to be re-evaluated. On 2/19/24 at 1:00 PM a note read, Resting in bed at present. Alert. Speech clear. Calls out at times. Moaning earlier in shift with PRN analgesic given with some relief. Resp even and unlabored. Cont to receive skilled therapy services related to hip fx. Call light in reach. On 2/19/24 at 5:14 PM a note read, Psych provider in to see resident earlier in shift with new order noted. Attempted to contact guardian x 2 with no answer, no voicemail. MD in to see resident earlier in shift as well. Informed of c/o pain and calling out, NNO (no new orders). On 2/20/24 at 11:53 AM a note read, NP (nurse practitioner) in to see resident for continued cos of pain new orders for gabapentin 100 mgs 2 caps by mouth twice daily for pain, repeat bilateral hip x-rays for pain . A note dated 2/24/24 at 11:25 read, 2/21/24 IDT meeting conducted with resident discussed due to recent increase in c/o pain and decline in wt and po intake. Overall condition has declined, MD following as well as RD. Resident c/o pain at times, calls out frequently. PRN analgesic given per orders with some relief. X-rays obtained with no acute findings. Resident turned and positioned as will allow for comfort as well as offloading. Continues to receive therapy services, unable to tolerate at times. Continue current POC (plan of care). MD and NP following closely during facility visits. On 3/5/24 at 10:50 AM a note read, Resident was in pain contacted hospice to see if could administer a 5 mg hydrocodone since we haven't received the 10 mg hydrocodone and they said yes to administer the 5 mg through the night until receive the 10 mg. No other complications this shift. It is unclear when or who ordered the hospice consult, when hospice started or when the order for hydrocodone changed to 10 mg by reading the facility notes. The provider's notes were reviewed. On 2/9/24 the NP documented, .she does have a history of a hip fracture and will be monitored closely for any recurrent pain . The note went on to state that R448 was not complaining of any pain at this time. On 2/13/24 the NP documented, Chief complaint/nature of presenting problem: Pain control. The note stated that R448 was being seen today for follow up on pain control. Patient's chart was being reviewed. Pain was noted at 7 from this mornings nursing assessment. Patient has hydrocodone 5/325 q 4 hours as needed, however upon review patient is only receiving this medication 1-2 times daily. I have requested that nursing complete routine pain assessments to determine if patient is requiring more frequent administration of her hydrocodone 5/325. On 2/16/24 the NP documented, Continues with pain, patient has pain medication as needed, staff requested to complete thorough pain assessments. On 2/19/24 the physician saw resident for a recertification visit. There was no mention of pain in the note other than to say, Per nursing patient did just receive her pain medication. On 2/20/24 the NP documented, Chief complaint/nature of presenting problem: bilateral hip pain. Patient unfortunately continues to show signs of pain to bilateral hips. Patients bilateral hip x-ray most recently was nonconclusive, it did not show any fracture but recommended repeat scan if symptoms continued to occur. Gabapentin (was already taking this for nerve pain prior to the hip fracture) will also be adjusted for pain management. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The medication administration record (MAR) was reviewed. There was an order dated 1/18/24 that read, Monitor: Pain, Does resident have pain? 0 = none; 1 = very mild; 2 = mild; 3 = some distress; 4 = distressing; 5 = moderate; 6 = severe; 7 = very severe; 8 = horrible; 9 = excruciating; 10 = worst possible. Document any nonpharmacological or pharmacological interventions used. The staff had just checked off the order twice daily for the duration of her stay, there was no pain scale attached, and no nonpharmacological interventions attached. There was an order for hydrocodone 5/325 mg one tab every 4 hours as needed for pain with a start date of 1/18/24. There was a pain scale attached to the hydrocodone order, but it was only filled in when the medication was administered and there was no follow up pain scale documented anywhere. There was no documentation of any pain medication being administered to the resident on 3/4/24 or 3/5/24, despite the above note stating the resident was in pain and the nurse had contacted hospice to clarify the pain medication orders on 3/5/24. The hospice notes were reviewed. Hospice start of care date was 3/4/25 for terminal Alzheimer's disease. According to the hospice Client Medication Report, on 3/4/24 orders were given to increase hydrocodone to 10/325 mg every 4 hours for pain and dyspnea and for morphine concentrate 0.25 ml every hour as needed for pain and dyspnea. A hospice on call note dated 3/5/24 at 10:07 PM read in part, Reports patients hydrocodone was increased today from 5/325 mg to 10/325 mg. Reports has not received the hydrocodone 10/325 mg from the pharmacy yet. Caregiver asks if she should just give 2 tabs of the 5 mg. Instructed caregiver to continue the patient on hydrocodone 5/325 mg q 4 hours as needed until new prescription arrives from pharmacy and then d/c the 5/325 mg and start the 10/325 mg . A hospice note dated 3/7/24 read in part, .Facility staff reports they have a documented allergy to morphine but they do not know what prs reaction is. Pt has been taking A hospice note dated 3/8/24 read in part, .Facility nurse reports they have not received pts morphine concentrate from their pharmacy yet. Order was signed by the hospice MD and sent to the facility pharmacy on 3/4/24. This nurse called (name and location of pharmacy omitted) to ask why this med has not been sent to the facility. Pharmacy staff reports they have tried several times to contact someone at (facility name omitted) to ask about an allergy they have listed for pt to morphine. This nurse advised pharmacy and facility staff that pt does not have an allergy to morphine, only a sensitivity of mild nausea. On 5/5/25 at 2:20 PM this surveyor interviewed Licensed Practical Nurse (LPN) # 3 when asked what they would do if they had a resident that had recent surgery for a fractured hip and were having pain after being given their prn pain medication they stated, I would call the doctor and let them know it wasn't working. Surveyor asked if it would be appropriate to just put the resident on the rounding list to be seen when the NP or MD is in the building and they stated, No, we need to call them and get the dose increased or scheduled or something. On 5/6/25 at 3:05 PM this surveyor interviewed the NP. They stated they could not view R448's record as they no longer had access to the computer program utilized at the time the resident was here. They stated they did not recall much about the resident. When asked why they did not increase or change R448's pain medication when informed the resident was having pain they stated, I would have to look back at my notes. This surveyor informed NP that they had instructed the nursing staff on two different occasions to conduct routine pain assessments and asked what the expectation would have been for that. They stated, I'm not sure, I would have to look back at the notes but I would expect that they would assess the pain at least every shift and document that somewhere. This surveyor asked what they would expect a nurse to do for a resdent who was still having significant pain after receiving their prn pain medication they stated, I would expect them to contact the on-call. They stated they would not expect the resident to have to wait until the next rounding day for relief. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The policy entitled, Pain was reviewed. Under the heading Procedure the document read in part, 2. The staff and physician will identify the characteristics (severity, location, intensity, frequency, duration, etc.) of pain. - Staff should use a consisten pain assessment approach appropriate to the resident/patient's cognitive level. 3. The staff and physician will evaluate how pain is affecting mood, activities of daily living, sleep and quality of life, as well as contributing to complications such as deconditioning, gait disturbances, social isolation, and falls. Under the heading Treatment/Management the document read in part, 8. The physician will order appropriate non-pharmacological interventions and medications to address the individual's pain, consistent with recognized protocols and guidelines. Under the heading Monitoring the document read in part, 11. The staff will reassess the individual's pain and its consequences at regular intervals; for example, at least each shift for unstable or increasing pain or significant [NAME] in levels of chronic pain, and at least weekly for stable chronic patients. - Review should include frequency, duration and intensity of pain; ability to perform activities of daily living, sleep pattern, mood, behavior, and participation in activities. On 5/6/25 at 4:30 PM the survey team met with the Administrator, Director of Nursing and the Administrator in Training. This concern was reviewed with them at that time. No further information was provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place at Wytheville - Birdmont Center	990 Holston Rd Wytheville, VA 24382

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **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 provide appropriate care and services to address trauma-informed care in accordance with professional standards of practice for (1) one of (30) thirty sampled residents, (Resident #77) The findings included: For Resident #77, the facility staff failed to properly assess the residents' experiences and preferences in order to identify and/or eliminate and/or mitigate potential triggers that have the potential to cause re-traumatization in relation to a diagnosis of post-traumatic stress disorder (PTSD). Resident #77's diagnosis list indicated diagnoses, which included, but not limited to, Hemiplegia and Hemiparesis, Cerebral Infarction, Type 2 Diabetes Mellitus, Hypertensive Heart Disease, Depressive Episodes, Anxiety Disorder, Post-Traumatic Stress Disorder (PTSD), Suicidal Ideations, and Mood Affective Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of [DATE] assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of Section I (Active Diagnoses) was coded to indicate Resident #77 has Post-Traumatic Stress Disorder. A psychiatry progress note dated [DATE] read in part, .Patient reports ongoing anxiety and depression. She also reports experiencing visual hallucinations, describing an incident where her deceased father visited her in her room. She denies any nightmares .Post-traumatic stress disorder .Patient's PTSD is managed with a combination of medications .She reports visual hallucinations, specifically seeing her deceased father. However, she denies any nightmares. Plan: Will continue current medication regimen and monitor for any changes in hallucinations or other PTSD symptoms. Encouraged patient to discuss hallucinations and any distressing memories or experiences . A psychiatry progress note dated [DATE] read in part, .Patient reports ongoing anxiety and depression .She continues to experience both visual and auditory hallucinations .Patient's PTSD is being managed with her current medication regimen. She denies any nightmares, which is a common symptom of PTSD. However, she reports occasional hallucinations. Plan: No changes to her current medication regimen at this time. Will continue to monitor her PTSD symptoms closely .Patients triggers for PTSD are nightmares and hallucinations . A review of the clinical record did not disclose any trauma-informed care associated assessments. Review of the comprehensive person-centered care plan disclosed a focus with an initiated date of [DATE], that read in part, .Reports PTSD of finding spouse in bed expired . No triggers were identified as part of the care plan interventions. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:55 AM, surveyor spoke with administrative staff #4 (AS#4) and asked about care planning and interventions for a resident with a diagnosis of PTSD. AS#4 stated if she knows and the symptoms are severe enough, she would put special engagements in place. She stated the IDT (interdisciplinary team) did not address or discuss Resident #77's PTSD while she (AS#4) was present in the care plan meeting. On [DATE] at 10:05 AM in an interview with the administrator, surveyor inquired what his expectation is for resident's diagnosed with PTSD and he stated his expectation is for staff to properly assess them and discuss as a team. He agreed staff did not identify potential triggers for Resident #77 or put interventions into place. He stated staff needs education on trauma-informed care. On [DATE] at 10:15 AM, surveyor was provided with a copy of the [DATE] psychiatry progress note and it disclosed a highlighted component that read in part, PTSD .She denies any nightmares .occasional hallucinations .Patients triggers for PTSD are nightmares and hallucinations which have improved with her current medication regimen . Below the highlighted note context the word Careplanned and licensed practical nurse #3's signature were written on the page. This concern was discussed on [DATE] at 4:15 PM during the end of day meeting with the administrator, director of nursing and administrator in training. On [DATE], surveyor reviewed Resident #77's care plan again, and a focus with an initiated date of [DATE] read in part, .resident has dx (diagnosis) of PTSD she is at risk for nightmares, hallucinations which can be triggers to her PTSD . Review of the related interventions disclosed interventions that read in part, .be alert to any factors that could lead to an increase in triggers .be alert to any reports from resident of nightmares . Surveyor requested and received a facility policy titled, Trauma Informed Care that read in part, Purpose-To guide staff in appropriate and compassionate care specific to individuals who have experienced trauma . Preparation .2. Nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization .General Guidelines .2. Trauma-informed care is .person-centered. 3. Caregivers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers . Organizational Strategies .6. Implement universal screening of residents for trauma .Resident-Care Strategies 1. As part of the comprehensive assessment, identify history or trauma .Identifying past trauma or adverse experiences may involve record review or the use of screening tools. 2. Utilize trained and qualified staff members .to assess him or her for previous trauma .4. Reduce or eliminate unnecessary stimuli (noise, lighting, unwanted or sudden physical contact, etc.) . No further information was provided to the survey team prior to exit on [DATE].

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	495349	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interviews, clinical record review, and facility document review, the facility staff failed to ensure medical provider orders were signed by the ordering provider when the orders were entered into residents' clinical records by non-prescribing facility staff members for 1 of 30 sampled residents (Resident #90). The findings include: A medical provider failed to sign orders entered by non-prescribing facility staff members on behalf of the prescriber. 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. Resident #90's following orders, which were entered by non-prescribing staff members, were not signed by a medical provider: - An order for pantoprazole 40mg by mouth once a day was ordered on 1/22/25 at 2:39 p.m. - An order for famotidine 40mg by mouth once a day was ordered on 1/22/25 at 2:39 p.m. - An order for a urology consult ASAP was ordered on 1/22/25 at 3:04 p.m. - An order for insulin 25 units to be injected subcutaneously at bedtime was ordered on 1/22/25 at 2:39 p.m. - An order for insulin 10 units to be injected subcutaneously before meals was ordered on 1/22/25 at 2:39 p.m. The following information was found in a facility policy titled Physician Services (with a revised date of April 2013): Physician orders and progress notes shall be maintained in accordance with current OBRA regulations and facility policy. The following information was found in a facility policy titled Verbal Orders (with a revised date of February 2014): The practitioner will review and countersign verbal orders during his or her next visit. The following information was found in a facility policy titled Telephone Orders (with a revised date of February 2014): Telephone orders must be countersigned by the physician during his or her next visit. (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/25 at 1:13 p.m., the surveyor asked the Assistant Director of Nursing (ADON) about Resident #90's orders that had not been signed/cosigned by the ordering prescriber. The ADON confirmed the orders had not been signed due to the orders being entered incorrectly as Prescriber written instead of as a verbal or telephone order. In the facility electronic record, orders entered as Prescriber written does not allow/require the ordering provider to sign/cosign the order. 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 Resident #90's ordering provider to sign/cosign the aforementioned orders.

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	495349	A. Building B. Wing	05/07/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **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. The findings included: 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. According to the current Facility assessment dated [DATE], the average daily census for this 107 certified bed facility was 98. 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. 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. 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. 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. 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. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/07/25.

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	495349	A. Building B. Wing	05/07/2025

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and facility document review, the facility staff failed to ensure the Director of Nursing (DON) did not serve as a charge nurse. The findings included: For this 107 certified bed facility, the DON served as a charge nurse and/or certified nursing assistant (CNA) providing direct resident care on 14 occasions between 1/01/25 through 4/30/25. According to the current Facility assessment dated [DATE], the average daily resident census was 98. On 5/02/25 at 1:06 PM, surveyor spoke with the DON regarding staffing and the DON stated she did work the medication cart at times. 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. Surveyor requested and received the dates of when the DON served as a nurse or CNA since 1/01/25. According to the provided report, the DON worked as a floor nurse nine days and as a CNA five days from 1/01/25 through 4/30/25. On 5/05/25 at 1:22 PM, surveyor spoke with the Administrator who stated he knew this was more than a 60-bed facility and they had agreed they would rather get a DON tag versus not having care for the residents. The Administrator stated having the DON work on the floor was always a last resort. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/07/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, staff interview, facility document review, and during a medication pass and pour observation, the facility staff failed to maintain an accurate record of controlled drugs for (2) two of (30) sampled residents, (Resident #201 and Resident #51). The findings included: Surveyor observed a medication pass and pour with licensed practical nurse (LPN#1) on 4/30/25. On 4/30/25 at 9:21 AM, surveyor observed LPN#1 prepare medications for Resident #201, that included one (1) tablet of Oxycodone 5/325 mg (milligrams). LPN#1 did not sign the medication out in the narcotics book at the time of preparation. The nurse administered the Oxycodone at 9:34 AM to Resident #201. LPN#1 did not sign the medication out in the narcotics book after returning to the medication cart. Surveyor observed a medication pass and pour with LPN#2 on 4/30/25. On 4/30/25 at 9:48 AM, surveyor observed LPN#2 prepare medications for Resident #51, that included (1) one tablet of Gabapentin 100 mg. LPN#2 did not sign the medication out in the narcotics book at the time of preparation. The nurse administered the Gabapentin at 9:49 AM to Resident #51. LPN#2 did not sign the medication out in the narcotics book after returning to the medication cart. This concern was discussed at the end of day meeting on 4/30/25 at 4:57 PM with the administrator, director of nursing, and administrator in training. Surveyor requested and received a facility policy titled, Controlled Substance Medication Orders, that read in part, .Applicable .protocols .are kept on file in the facility and are followed closely . No other information was provided to the survey team prior to exit on 5/7/25.

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	495349	A. Building B. Wing	05/07/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on staff interview, clinical record review, and facility document review the facility staff failed to ensure the medical provider reviewed medication regimen reviews in a timely manner for (1) one of (30) sampled residents, (Resident #36). The findings included: For Resident #36 the facility staff failed to provide evidence of the 8/26/24 medication regimen review (MRR) being reported to and acted upon by the medical provider in a timely manner. Resident #36's diagnosis list indicated diagnoses that included but were not limited to Hypertension, Seborrheic Dermatitis, Alzheimer's Disease with Early Onset, Chronic Respiratory Failure with Hypoxia, Cerebrovascular Disease, Type 2 Diabetes Mellitus, Epilepsy, Depression, Anxiety, Dementia, Chronic Kidney Disease-Stage 2, and Schizoaffective Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/6/25, assigned the resident a brief interview for mental status (BIMS) summary score of 5 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. Progress notes within R36's clinical record indicated a MRR was completed by a pharmacist on 8/26/24 with recommendations. Surveyor was unable to locate the 8/26/24 recommendation report in the resident's clinical record. Surveyor requested and received the MRR recommendation report completed by the pharmacist from the director of nursing. She agreed that the MRR dated 8/26/24 had not been acknowledged or signed by a medical provider indicating acknowledgement and review until 11/26/24. The 8/26/24 Note to Attending Physician/Prescriber read in part .This resident has been taking the antipsychotic Olanzapine 5 mg (milligrams) daily at HS (at bedtime) since 2/24. Please evaluate the current dose and consider a dose reduction. (resident's other psychoactive meds (medications) are Clorazepate 3. 75 mg, Citalopram 5 mg daily) . The medical provider provided a rationale dated 11/26/24 that read in part, .Disagree .Patient is stable at current dose. Dose reduction attempt at this time would put patient at high risk for decompensation . This concern was discussed at the end of day meeting on 5/1/25 at 4:15 PM with the administrator, director of nursing, and administrator in training. Surveyor requested and received a facility policy titled, Medication Regimen Reviews that read in part, .11. If the Physician does not provide a timely .response, or the Consultant Pharmacist identifies that no action has been taken, he/she contacts the Medical Director or (if the Medical Director is the physician of record) the Administrator .12. The attending physician documents in the medical record that the irregularity has been reviewed . (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to exit on 5/7/25.

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	495349	A. Building B. Wing	05/07/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, the facility staff failed to ensure residents were free of significant medication errors for 3 of 30 sampled residents (Resident #26, Resident #62, and Resident #4). The findings included: 1. For Resident #26, the facility staff failed to correctly transcribe and administer an intravenous (IV) antibiotic as ordered by the medical provider to treat a urinary tract infection. Resident #26's diagnosis list indicated diagnoses, which included, but not limited to Acute Cerebrovascular Insufficiency and History of Urinary Tract Infections. 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. Resident #26's comprehensive person-centered care plan included a focus area stating the resident had a history of urinary tract infections (UTIs). Resident #26 was readmitted to the facility on [DATE] at approximately 5:00 PM following a brief hospital stay. The 2/02/25 hospital Discharge Summary indicated Resident #26 was diagnosed with an acute UTI while hospitalized . The discharge summary read in part .Urinalysis turbid in appearance with RBCs [red blood cells] too numerous to count, 5-10 wbc's [white blood cells] and many bacteria. Some gross hematuria noted. The patient was treated with IV Rocephin for possible acute cystitis. Urine culture positive for Proteus mirabilis . The discharge summary included orders for Ceftriaxone Sodium (Rocephin) 2 grams IV once daily for five (5) days. Upon readmission, the antibiotic order for Ceftriaxone Sodium (Rocephin) was transcribed and entered in Resident #26's clinical record on 2/02/25 as Ceftazidime 2 grams IV at bedtime for five (5) days instead of Ceftriaxone Sodium (Rocephin). Resident #26 was seen by the nurse practitioner (NP) 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 . Resident #26 returned to the facility on 2/02/25 at approximately 5:00 PM and according to the resident's February 2025 Medication Administration Record (MAR), she received the first dose of Ceftazidime 2 grams IV on 2/07/25. The resident never received Ceftriaxone Sodium (Rocephin). 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/02/25 at 11:15 AM surveyor spoke with the NP who stated the antibiotic on the discharge summary was just missed. Surveyor requested and received the facility policy titled Admission/readmission Orders which read in part 6. The physician will review all orders carefully for accuracy and completeness . On 5/05/25 at 4:05 PM, the survey team met with the Administrator and DON and discussed the concern regarding Resident #26 being readmitted to the facility on [DATE] with orders for Ceftriaxone Sodium IV per the hospital discharge summary however Ceftazidime IV was ordered instead of the Ceftriaxone Sodium and the first dose of Ceftazidime was not administered until 2/07/25. On 5/06/25, the facility provided a copy of a 5/05/25 5:14 PM nursing progress note that read Spoke with [medical director] concerning medication error on IV antibiotic given in Feb of 2025. [Medical director] reviewed antibiotic sensitivities of antibiotic given. Bacteria noted to be susceptible to that antibiotic as well and resident is not noted to have an allergy to this med, [medical director] in agreement that no further action needs to be taken at this time. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/07/25. 2. For Resident #62, the facility staff failed to follow the medical provider orders for the administration of Carvedilol, a medication used to treat heart failure and hypertension, on two separate occasions. Resident #62's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Atherosclerotic Heart Disease of Native Coronary Artery, and Essential Hypertension. 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. Resident #62's current comprehensive person-centered care plan included a focus area stating The resident has coronary artery disease (CAD) r/t [related to] Hypertension with an intervention stating in part Give all cardiac meds as ordered by the physician . Resident #62's medical provider orders included an order for Carvedilol 3.125 mg orally two times a day, hold for systolic blood pressure less than 100 or pulse less than 60. A review of Resident #62's April 2025 Medication Administration Record (MAR) revealed Carvedilol was administered on the morning of 4/07/25 with a pulse of 59 and on the morning of 4/24/25 with a pulse of 59. On 5/01/25 at 4:34 PM, the survey team met with the Administrator, Administrator in Training, and the Director of Nursing and discussed the concern of staff failing to follow the medical provider orders for the administration of Carvedilol on two occasions for Resident #62. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/07/25. (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place at Wytheville - Birdmont Center	990 Holston Rd Wytheville, VA 24382

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. For Resident #4, the facility staff failed to follow the medical provider orders for the administration of Metoprolol Tartrate, a medication used to treat chest pain and hypertension, on two separate occasions. Resident #4's diagnosis list indicated diagnoses, which included, but not limited to Paroxysmal Atrial Fibrillation and Multiple Myeloma. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/19/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #4's medical provider orders included an order for Metoprolol Tartrate 25 mg give one-half tablet two times a day related to paroxysmal atrial fibrillation, hold for systolic blood pressure less than 110 or pulse less than 65. A review of Resident #4's April 2025 Medication Administration Record (MAR) revealed the resident received Metoprolol Tartrate on 4/19/25 in the morning with a documented blood pressure of 109/70 and again at bedtime on 4/19/25 with a documented blood pressure of 109/70. On 5/01/25 at 4:34 PM, the survey team met with the Administrator, Administrator in Training, and the Director of Nursing and discussed the concern of staff failing to follow the medical provider orders for the administration of Metoprolol Tartrate for Resident #4. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/07/25.

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	495349	A. Building B. Wing	05/07/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and facility document review, the facility staff failed to ensure the safe and secure storage of medications and biologicals for (1) one of (5) five facility medication carts. The findings included: On 4/30/25 at 11:39AM, surveyor observed an unattended, unlocked medication cart on the nursing unit. Licensed practical nurse #1 (LPN#1) approached the medication cart and surveyor asked her if this was her medication cart and she stated, Yes. Surveyor informed LPN#1 the cart was observed unlocked and the nurse then locked the medication cart. This concern was discussed at the end of day meeting on 4/30/25 at 4:57 PM with the administrator, director of nursing, and administrator in training. Surveyor requested and received a facility policy titled, Security of Medication Cart, that read in part, .4. Medication carts must be securely locked at all times when out of the nurse's view . No other information was provided to the survey team prior to exit on 5/7/25.

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	495349	A. Building B. Wing	05/07/2025

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to obtain laboratory services to meet the needs of 2 of 30 sampled residents, Resident #348 and #77. The findings included: 1. For Resident #348, the facility staff failed to obtain a urinalysis as ordered on 4/25/25. Resident #348's diagnosis list indicated diagnoses, which included, but not limited to Streptococcal Sepsis, Chronic Kidney Disease Stage 5, and Hypertensive Heart Disease. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/26/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #348's comprehensive person-centered care plan included a focus area stating, The resident has renal insufficiency r/t [related to] Chronic Kidney Disease Stage 5, history of Kidney Stones and UTIs [urinary tract infections] with an intervention stating, Medication and Labs per order. Resident #348 was seen by the nurse practitioner (NP) on 4/25/25, the progress note read in part .Patient presents with symptoms consistent with a urinary tract infection (UTI) and requests a urinalysis (UA) to confirm the diagnosis. Plan: Ordered a stat UA to evaluate for the presence of infection. Based on the results, appropriate antibiotic therapy will be initiated . Surveyor reviewed Resident #348's clinical record and was unable to locate evidence of a urinalysis being obtained following the 4/25/25 order. Resident #348's clinical record included an 4/29/25 1:27 PM nursing progress note which read Resident is complaining of flank pain and burning upon urination. FNP (family nurse practitioner) made aware. New order received to obtain UA C&S [urinalysis with culture and sensitivity]. A urinalysis was obtained on 4/29/25 at 3:30 PM. On 4/30/25 at 11:29 AM, surveyor spoke with Resident #348 who stated she had not had a urine sample obtained prior to yesterday. She further stated she was having burning with urination and her stomach hurt. On 4/30/25 at 12:49 PM, surveyor spoke with the NP regarding the urinalysis ordered on 4/25/25. NP stated she entered the order for the 4/25/25 urinalysis and does not know what happened but the order did not save in the system. NP stated the urinalysis was a routine order and not a stat order. The 4/29/25 urinalysis report returned on 4/30/25 positive for nitrites and few bacteria with no culture indicated. (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received the facility policy titled Lab and Diagnostic Test Results - Clinical Protocol which read in part .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 . On 5/01/25 at 4:34 PM, the survey team met with the Administrator, Administrator in Training (AIT), and the Director of Nursing and discussed the concern of staff failing to obtain a urinalysis according to the 4/25/25 provider order. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/07/25. 2. For Resident #77, the facility staff failed to obtain a urinalysis as indicated in a medical provider's progress note dated 3/28/25. Resident #77's diagnosis list indicated diagnoses, which included, but not limited to, Hemiplegia and Hemiparesis, Cerebral Infarction, Type 2 Diabetes Mellitus, Hypertensive Heart Disease, Depressive Episodes, Anxiety Disorder, Post-Traumatic Stress Disorder (PTSD), Suicidal Ideations, and Mood Affective Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/18/25 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A medical provider progress note dated 3/28/25 read in part, .The patient reports episodes of increased polyuria (a condition characterized by abnormally large urine output) .Patient has been experiencing episodes of increased urination, consistent with the diagnosis of polyuria .Plan: A urinalysis will be ordered to further evaluate the cause of the polyuria. Depending on the results of the urinalysis, further management strategies will be considered . Review of a medical provider orders for March 2025 did not disclose an order for urinalysis. A review of the laboratory/diagnostics section of the clinical record did not reveal a urinalysis was conducted on 3/28/25 or shortly thereafter. A medical provider progress note dated 4/14/25 read in part, .The patient reports dysuria (painful or burning urination) and abdominal pain, raising concerns for a potential UTI .Patient has been experiencing dysuria and abdominal pain, which could be indicative of a urinary tract infection. Acute. Plan: Order a urinalysis to confirm the presence of a urinary tract infection. If confirmed, appropriate antibiotic therapy will be initiated . urinalysis was ordered . A review of the urine culture results dated 4/17/25 revealed Resident #77's urine was positive for escherichia coli (e-coli) bacteria. A medical provider progress note dated 4/18/25 read in part, .Urinalysis results indicate a urinary tract infection, with sensitivity testing showing the greatest efficacy to Macrobid. Plan: Prescribed Macrobid 100 mg BID (twice daily) for 40 days. Will continue monitoring UTI symptoms and response to treatment . (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This concern was discussed on 5/1/25 at 4:15 PM during the end of day meeting with the administrator, director of nursing and administrator in training. On 5/2/25 licensed practical nurse #5 (LPN#5) informed surveyor the medical provider did not put the order in on 3/28/25 for a UA (urinalysis) for staff to confirm and collect. On 5/2/25 at 11:12 AM via phone conversation, surveyor interviewed the medical provider-other staff #3 (OS#3) and she stated she put the order in on 3/28/25 for the UA, but does not know what happened to it. She believes something went wrong in the (electronic) system somehow. She stated she did visit the patient again on 3/31/25 and the patient had no urinary symptoms at that time. When asked if she felt the UA positive for e-coli on 4/17/25 was related to the resident not being tested on [DATE], OS#3 stated it's hard to say and she rounded with the resident frequently and the resident did not have any symptoms. She stated if the resident did have symptoms, she would have ordered a STAT (immediate need) UA. Surveyor requested and received a facility policy titled, Lab and Diagnostic Test Results-Clinical Protocol that read in part, .The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs . No further information was provided to the survey team prior to exit on 5/7/25.

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	495349	A. Building B. Wing	05/07/2025

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on staff interview, record review and facility document review the facility staff failed to promptly notify the ordering provider of laboratory results that fell outside clinical reference ranges, in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders for 1 (one) of 30 residents in the survey sample, resident # 15 (R15). The findings included: For R15 the facility failed repeatedly to notify the provider of urinalysis with culture and sensitivity results that indicated the resident had a urinary tract infection (UTI) which delayed treatment for the UTI. R15's diagnoses included but were not limited to, chronic renal failure stage IV (severe), benign prostatic hypertension, and obstructive and reflux uropathy. The minimum data set (MDS) assessment for R15 with an assessment reference date of 2/20/25 assigned the resident a brief interview for mental status (BIMS) score of 7 out of 15, indicating moderate cognitive impairment. During a review of the clinical record, a progress note dated 2/24/25 at 3:19 PM read, Resident returned from appointment at this time and new order obtained to obtain urinalysis with culture and sensitivity. No other orders obtained at present. Resident own RP and aware of new order. On 2/25/25 at 4:35 PM a note read, Reagan from Vista lab called at this time and notified nurse that Urine specimen sent this am could not be used due to missing information on specimen cup. New UA specimen obtained. NP notified. The results of the urinalysis (UA) were in the clinical record under the results tab with a collection date, received date and reported date of 2/26/25. The results of the UA were indicative of a UTI with the urine being turbid (cloudy or hazy) in appearance, positive for blood and bacteria and 250 leukocyte esterase (the presence of white blood cells indicating potential infection). The urine culture was there as well with a reported date of 2/28/25 and was indicative of a UTI with greater than 100,000 colonies of gram negative rods (a common type of bacteria common in UTI's). The Nurse Practitioner (NP) saw R15 on 2/28/25. The progress note for the visit stated the resident was being seen for a mild cough and phlegm in the back of his throat. There was no mention of a UTI or of the urinalysis and urine culture. (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/3/25 the NP was in to see R15 again. The note read in part, .presenting with increased urinary frequency and dysuria. Under the heading labeled Assessment and Plan the note read, The patient presents with complaints of increased frequency of urination and burning sensation, which are consistent with a urinary tract infection (UTI). A urinalysis with culture and sensitivity has been ordered to confirm the diagnosis and identify the causative organism. Plan: The patient will be placed on a UTI protocol, which likely includes empiric antibiotic therapy pending the results of the culture and sensitivity. Staff has been instructed to encourage the patient to increase fluid intake, as hydration can help flush out bacteria from the urinary tract. The patient will be monitored for improvement in symptoms and response to treatment. There was no mention of the urine and urine culture already performed and resulted from the order on 2/24/25. A progress note dated 3/4/25 at 7:02 AM read, UA obtained and Vista Clinical transported this AM. Under the results tab, the UA results were there with a collected, received and reported date of 3/4/25. The UA showed the urine was turbid in appearance with 500 leukocyte esterase and was positive for blood and bacteria. The culture had a reported date of 3/6/25 and again showed greater than 100,000 colonies of gram negative rods. There was no further documentation of anything regarding the urine or R15's symptoms until 3/11/25 when the NP was back in. The note read in part, The patient has a suspected UTI. A repeat urinalysis has been ordered, as the current culture is from 2/24/25. Under the heading Assessment and Plan the note read, The suspicion of a urinary tract infection is based on the patient's clinical presentation. A repeat urinalysis has been ordered as the current culture is from 224 25, which may not accurately reflect the current status of the infection. The patient's vitals, including a blood pressure of 144 over 70, respirations of 18, temperature of 97. 6, and pulse of 70, were noted. Plan: A UTI status has been ordered along with a repeat urinalysis to confirm the presence of a urinary tract infection. Depending on the results, appropriate antibiotics will be prescribed. The patient will be educated on the importance of completing the full course of antibiotics to prevent recurrence or resistance. The patient will also be advised on preventative measures such as proper hygiene and adequate hydration. A follow-up appointment will be scheduled to assess the patient's response to treatment and to ensure resolution of the infection. This surveyor was unable to find any results for a UA dated on or around 3/11/25. There was an order entered to obtain a UA with C&S (culture and sensitivity) on 3/11/25. There was no further mention of the UTI until 3/17/25 when the NP was back in to see R15 and documented, The patient was noted by nursing home staff to have hematuria. Current urinalysis results are outdated. He is currently on UTI stat, which he appears to be tolerating well . Under the heading Assessment and Plan the note read in part, Noted presence of blood in the urine, which is consistent with the diagnosis of hematuria. The cause of the hematuria is not specified in the transcript. Plan: A repeat urinalysis will be ordered to further investigate the cause of the hematuria and to monitor its progression . This surveyor was not able to locate UA results dated on or around 3/17/25. There was no order located in the medical record for a UA on 3/17/25. There was no further mention of a UTI until the NP returned on 3/26/25. The note read in part, The patient has a UTI. Urinalysis with culture and sensitivity results were reviewed. Current vital signs include BP of 144/70 mmHg, respirations of 18 breaths per minute, temperature of 97.6 degree, and SpO2 of 97%. The note went on to state antibiotics were prescribed. (continued on next page)

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	495349	A. Building B. Wing	05/07/2025

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/25 at 11:35 AM this surveyor interviewed the NP. When asked about R15's UTI and why it took approximately one month to initiate treatment they stated, There was an issue with integration of the labs into the chart. If you look you will see that I did not review them until 3/26/25 and that is because they were not in there prior to then. That is when they showed up in the record and when I was able to review them. This surveyor asked if they had spoken with the nursing staff and asked them to call the lab to get results and they stated, I asked them all every time I came and nobody could tell me if the labs had been done, that's why I kept ordering them. On 5/2/25 at 12:40 PM this surveyor interviewed Licensed Practical Nurse (LPN) #3. They stated they were not aware that resident had went from 2/24/25 to 3/26/25 with a UTI untreated. They stated that the labs are integrated and are sent from the lab directly to the resident's record. They provided this surveyor with copies of the 2/26/25 UA C&S, as well as the 3/4/25 results. Someone had written has pending repeat UA @ (name of hospital omitted) with initials and a date of 3/11/25 On the 3/4/25 results The 2/26/25 results had initials with a date of 3/11/25. LPN # 3 stated the initials look to belong to the NP. The policy entitled, Lab and Diagnostic Test Results - Clinical Protocol was reviewed. Under the heading, Review by Nursing Staff the document read in part, 3. A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition. Under the heading Identifying Situations that Warrant Immediate Notification the document read in part, 1. Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: -Whether the physician has requested to be notified as soon as a result is received. - Whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). -Whether the resident/patient's clinical status is unclear or he/she has signs and symptoms of acute illness or condition change and is not stable or improving, or there is no previous results for comparison. On 5/6/25 at 4:30 PM the survey team met with the Administrator, Director of Nursing and the Administrator in Training. This concern was reviewed at that time. No further information was provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on staff interview, clinical record review, and facility document review, the facility staff failed to obtain timely diagnostic services to meet the needs of the residents for 1 of 30 sampled residents (Resident #4). The findings included: For Resident #4, the facility staff failed to follow the medical provider order to obtain a chest x-ray (CXR) in a timely manner. Resident #4's diagnosis list indicated diagnoses, which included, but not limited to Chronic Obstructive Pulmonary Disease, Multiple Myeloma, and Paroxysmal Atrial Fibrillation. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/19/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #4 was seen by the nurse practitioner (NP) on 4/09/25, the progress note read in part .presenting with a mild fever and chills .A chest x-ray will be ordered to rule out any respiratory infections that could be causing the fever . An order for a CXR to rule out pneumonia was entered into Resident #4's clinical record on 4/09/25 at 11:20 AM. The CXR was not obtained until 4/11/25. On 4/30/25 at 11:51 AM, surveyor spoke with the Director of Nursing (DON) who stated the order for the CXR was entered on the same order as a urinalysis but could not speak to why the CXR was not obtained until 4/11/25. On 5/02/25 at 11:23 AM, surveyor spoke with the NP regarding the delay in obtaining the CXR and the NP stated the facility was at the mercy of the radiology company. Surveyor requested and received the facility policy titled Availability of Services, Diagnostic which read in part .The following diagnostic services are available twenty-four (24) hours a day, seven (7) days a week, including holidays .g. Radiology . Surveyor reviewed the facility contract with the mobile imaging company dated 3/16/12 which read in part .2. 2.2 Provide quality Radiology Services to Facility Patients. In this regard, [name omitted] shall 2.2.1 make Radiology Services available for Facility Patients twenty-four hours per day, seven days a week . On 5/01/25 at 4:34 PM, the survey team met with the Administrator, Administrator in Training, and the Director of Nursing and discussed the concern of Resident #4's CXR not being obtained timely. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/07/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. Building B. Wing	05/07/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on resident interview, family interview, staff interview, clinical record review, and facility document review, the facility staff failed to maintain complete and/or accurate clinical records for two (2) of 30 sampled residents (Resident #39 and Resident #63). The findings include: 1. The facility staff failed to document the details of episodes of behaviors documented on Resident #63's medication administration record (MAR). Resident #63's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/4/25, was signed as completed on 3/5/25. Resident #63 was assessed as usually able to make self understood and as usually able to understand others. Resident #63's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact or borderline cognition. Resident #63's MAR for April 2025 had the resident documented as having two (2) episodes of behaviors on the following two (2) 7p.m. to 7a.m. shifts: (1) 4/10/25 and (2) 4/29/25. Resident #63's clinical documentation failed to include what the behaviors were. Resident #63's MAR for April 2025 included another section to document specific behaviors. This section read as follows: Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care . Document: 'N' if monitored and none of the above observed. 'Y' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. For the 4/10/25 and 4/29/25 7p.m. to 7a.m. shifts, the nurse documented 'N' indicating these behaviors were not observed. This did not address what behavior occurred that resulted in the documentation of 2 in the aforementioned behavior monitoring section of Resident #63's April 2025 MAR. The following information was found in a facility document titled Charting and Documentation (with a revised date of 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. - The following information is to be documented in the resident medical record: . Objective observations . Changes in the resident's condition . Events, incidents or accidents involving the resident . 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 Resident #63's aforementioned incomplete and/or incorrect behavior documentation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place at Wytheville - Birdmont Center	990 Holston Rd Wytheville, VA 24382

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For Resident #39, facility staff failed to ensure the clinical record included a provider order for laboratory studies that were obtained with results provided. Resident #39's diagnoses included but were not limited to urinary tract infection (UTI). In Section C (cognitive patterns) of Resident #39's minimum data set assessment with an assessment reference date of 03/26/25 coded the brief interview for mental status summary score 14 out of 15 which indicated intact cognition. Resident #39's clinical record contained a progress note, written by a licensed practical nurse (LPN) dated 04/21/25 at 5:23 p.m. which read, [Doctor's name omitted] made rounds, and the residents [sic] husband expressed concerns about her urine being cloudy. He ordered a U/A (urinalysis). A urine specimen was collected form [sic] the foley catheter and placed in the specimen refrigerator. Will be picked up by the lab in the morning. Results from the urinalysis, dated 04/22/25, and urine culture, dated 04/24/25, were included in the clinical record however, there was no provider order for the urinalysis or urine culture found. On 05/02/25, the director of nursing (DON) was interviewed about Resident #39's urinalysis and urine culture order. At 2:10 p.m. on that day, the DON acknowledged she was unable to find a provider order for the urinalysis and urine culture that had been obtained with results provided for Resident #39. The DON reported there was a progress note which read the medical provider wanted the laboratory studies. During an end of day meeting with the administrator, administrator-in-training, and DON on 05/06/25 at 4:28 p.m., the issue of laboratory studies, specifically urinalysis and urine culture having been completed without a provider order being formally put in the computer system was discussed. No further information was provided prior to the exit conference.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, and facility document review, the facility staff failed to maintain infection prevention and control practices during medication administration for 1 of 2 nursing units. The findings included: Surveyor observed a medication pass and pour with licensed practical nurse (LPN#1) on 4/30/25. At 9:16 AM surveyor observed LPN#1 place 1 tablet of a medication for Resident #198 in a small plastic pill cup. LPN#1 was then observed to place another medication cup with medications for Resident #199 on top of Resident #198's pill cup. LPN #1 then took both pill cups (stacked together) into Resident #199's room and administered medications to Resident #199. The nurse then proceeded to take Resident #198's medication to his room for administration. At 9:18 AM, LPN#1 began the medication pass for Resident #201 and donned gloves. She pulled the medications with gloves and then scored a Lasix tablet while wearing the same gloves. At 9:31 AM, LPN#1 took the pill cup containing the left-over ½ of Lasix tablet into Resident #201's bathroom and discarded it into the trash can. LPN#1 then removed the pill cup with the medication from the trash can and returned it to rest on the top of the medication cart. LPN#1 then discarded the medication into the sharp's container, threw the pill cup into the trash bin, and proceeded to start another resident's medications without sanitizing the medication cart. This concern was discussed at the end of day meeting on 4/30/25 at 4:57 PM with the administrator, director of nursing, and administrator in training. Surveyor requested and received a facility policy titled, Policies and Practices-Infection Control that read in part, .This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections .2 .b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public .f. Provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment . Surveyor requested and received a facility policy titled, Handwashing/Hand Hygiene that read in part, .This facility considers hand hygiene the primary means to prevent the spread of infections .2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . No other information was provided to the survey team prior to exit on 5/7/25.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and facility document review, the facility staff failed to provide effective communication training for one of five sampled direct care staff members, Certified Nursing Assistant (CNA) #1. The findings included: The facility staff failed to provide evidence of effective communication training for CNA #1. On 5/06/25, surveyor reviewed CNA #1's provided in-service training record. The record failed to include evidence of effective communication training. Surveyor requested and received the Facility assessment dated [DATE] which read in part .Our facility makes a good faith effort to provide the staff training/education and competencies necessary to provide the level and types of support and care needed for our resident population. Our facility has identified the following training topics that may be utilized by our staff including managers, nursing, direct care staff, contracted individuals and volunteers consistent with their expected roles. This is not an inclusive list. Communication: effective communications for direct care staff . On 5/06/25 at 4:28 PM, the survey team met with the Administrator, Administrator in Training, and the Director of Nursing and discussed the facility failing to provide evidence of CNA #1 receiving effective communication training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and facility document review, the facility staff failed to provide behavioral health training for 5 of 5 sampled Certified Nursing Assistants (CNAs) #1, #2, #3, #4, and #5. The findings included: For CNAs #1, #2, #3, #4, and #5, the facility staff failed to provide evidence of behavioral health training. On 5/06/25, surveyor reviewed CNA #1, #2, #3, #4, and #5's in-service training records. The records failed to include evidence of behavioral health training. CNAs #1, #2, #3, and #5 had only completed the trauma-informed care portion of behavioral health training. Surveyor reviewed the Facility assessment dated [DATE] which read in part .Services and Care We Offer Based on Residents' Needs .Mental Health and Behavior. Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD [post-traumatic stress disorder], other psychiatric diagnoses, intellectual or developmental disabilities, SUD [substance use disorder], traumatic brain injury .Our facility makes a good faith effort to provide the staff training/education and competencies necessary to provide the level and types of support and care needed for our resident population. Our facility has identified the following training topics that may be utilized by our staff including managers, nursing, direct care staff, contracted individuals and volunteers consistent with their expected roles. This is not an inclusive list .Behavioral health, i.e., substance use disorder . Surveyor requested and received the facility policy titled Behavioral Health Services which read in part .5. Staff training regarding behavioral health services includes, but is not limited to: a. Recognizing changes in behavior that indicate psychological distress; b. Implementing care plan interventions that are relevant to the resident's diagnosis and appropriate to his or her needs; c. Monitoring care plan interventions and reporting changes in condition; and d. Protocols and guidelines related to the treatment of mental disorders, psychological adjustment difficulties, history of trauma and post-traumatic stress disorder . The current Facility assessment dated [DATE] indicated the facility cared for an average of 5 to 12 residents with behavioral health needs and 0 to 5 residents with active or current substance use disorders. Upon survey entrance on 4/29/25, the facility Resident Matrix identified two (2) residents with PTSD/Trauma. On 5/06/25 at 4:28 PM, the survey team met with the Administrator, Administrator in Training, and the Director of Nursing and discussed the concern of staff failing to provide evidence of behavioral health training for CNAs #1, #2, #3, #4, and #5.