STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place at Botetourt Commons	290 Commons Parkway Daleville, VA 24083

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure the correct code status was in place for 1 of 19 residents in the survey sample, Resident #46. The findings included: For Resident #46, the current code status order was full code, however the comprehensive person-centered care plan and the clinical record Advanced Directive information tab documented the resident as having a DNR (do not resuscitate) decision in place. The resident's clinical record also included a completed Durable Do Not Resuscitate [DDNR] Order. Resident #46's diagnosis list indicated diagnoses, which included, but not limited to Acute Follicular Conjunctivitis, Chronic Pain Syndrome, Open-Angle Glaucoma, Type 2 Diabetes Mellitus, Schizophrenia, and Congestive Heart Failure. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/12/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #46's current provider orders included an order dated 3/15/24 for Full Code. The resident's comprehensive person-centered care plan included a care plan dated 3/15/24 stating Resident has the following Advanced Directive on record: DNR. Resident #46's clinical record documented the resident as having an active DNR status in the section of Advanced Directives. The resident's clinical record also included a completed DDNR dated 3/03/23 signed by the resident. On 4/09/24 at 3:06 PM, the survey team met with the Administrator and Director of Nursing (DON) and discussed the concern of Resident #46 having conflicting documentation regarding their code status. (continued on next page)

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
	495386	A. Building B. Wing	04/10/2024

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Carrington Place at Botetourt Commons	290 Commons Parkway Daleville, VA 24083

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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 - Few	On 4/10/24 at 5:05 PM, surveyor spoke with the DON who stated when Resident #46 was readmitted from a hospital stay, the resident had rescinded their decision to have a DNR status, but they talked with the resident yesterday and Resident #46 wanted to remain a DNR at this time. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/10/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495386	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER: Carrington Place at Botetourt Commons		STREET ADDRESS, CITY, STATE, ZIP CODE: 290 Commons Parkway Daleville, VA 24083	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34307 Based on observation, Resident interview and staff interview the facility staff failed to provide a clean, comfortable, and homelike environment for 1 of 19 residents, Resident #63. The findings included: For Resident #63 the facility staff failed to ensure the resident's room was free from odors. Resident #63's face sheet listed diagnoses which included but not limited to Parkinsonism, hypertension, and encounter for palliative care. Resident #63's most recent minimum data set with an assessment reference date of 03/11/24 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that that the resident is cognitively intact. On 04/08/24 at 1:30 pm, while speaking with Resident #63, surveyor observed a strong odor of urine in the resident's room. Surveyor spoke with Resident #63 again on 04/09/24 at 11am. There was again a strong odor of urine in the resident's room. Surveyor spoke with certified nurse's aide (CNA) #2 outside of resident's room at this time. Surveyor asked CNA #2 if they could identify the odor in Resident #63's room, and CNA #2 stated, Oh, it's urine. CNA #2 stated that it was from the resident's roommate, who refuses showers. CNA #2 stated they were attempting to get roommate to shower. Surveyor observed licensed practical nurse (LPN) #4 standing in hallway outside Resident #63's room at 12:20 pm. When surveyor walked by, LPN #4 stated, I can't breathe in there, referring to Resident #63's room. Surveyor asked LPN #4 why they couldn't breathe in the room and LPN #4 stated, The smell. Surveyor asked LPN #4 what the smell was, and LPN #4 stated, I don't know, I've only been a nurse for a year but I have never smelled anything like that. Surveyor spoke with Resident #63 on 04/09/24 at 2:25 pm. Surveyor asked Resident #63 if the odor in the room bothers them, and Resident #63 stated they have sinus problems, and can't smell. The concern of the strong odor of urine in Resident #63's room was discussed with the administrator and director of nursing on 04/09/24 at 3:15 pm. Surveyor observed housekeeping staff cleaning Resident #63's room on 04/09/24 at 4:10 pm. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495386	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
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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. 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to implement a comprehensive person-centered care plan to meet the needs of the resident for 1 of 19 residents in the survey sample, Resident #2. The findings included: For Resident #2, the facility staff failed to implement the comprehensive person-centered care plan (CPCCP) intervention and registered dietitian's (RD) recommendation to weigh the resident weekly. Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Multiple Sclerosis, Vascular Dementia, Epilepsy, Hemiplegia Affecting Right Dominant Side, Dysphagia Following Cerebral Infarction, and Atrial Fibrillation. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/23/24 assigned the resident a brief interview for mental status (BIMS) summary score of 5 out of 15 indicating the resident was severely cognitively impaired. The resident was coded for the presence of a feeding tube in which they received 51% or more of total calories during the previous seven (7) days. A review of Resident #2's CPCCP revealed a care plan goal of Tolerates tube feeding as ordered with interventions dated 5/02/22 to Weigh weekly and Refer to Dietician for evaluation of current nutritional status and determine formula options. A review of Resident #2's clinical record on 4/08/24, revealed the following: Resident #2 was reviewed by the RD on 1/30/24, the progress note read in part .Recommend weekly weight on TF [tube feeding] . An additional RD progress note dated 2/26/24 read in part .Recommend weekly weight on TF . The most recent RD progress note dated 4/02/24 read in part .2/08/24 112.3 # [pounds] .Would benefit from updated weight measurement for serial assessment .Recommended updated wt [weight] measurement and weekly weights on TF. On 4/08/24, surveyor reviewed Resident #2's clinical record and was unable to locate evidence of weekly weights. On 4/09/24 at 3:48 PM, surveyor spoke with the Director of Nursing (DON) and requested documentation of the resident's weekly weights. On 4/09/24 at 1:37 PM, the DON provided a document titled Weight Change History for Resident #2 with the following weights documented: 11/15/23 116.90, 12/07/23 128.00, 12/28/23 130.40, 1/30/24 132.40, 2/08/24 112.30, 3/06/24 114.20, 4/09/24 116.20. Surveyor requested evidence of weekly weights being obtained for Resident #2, DON stated they would look for weekly weights. On 4/10/24 at 3:26 PM, surveyor spoke with the DON who stated they could only locate monthly weights for Resident #2. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received the facility policy titled Weight Assessment and Intervention which read in part .Weights will be recorded in each unit's Weight Record chart or notebook and in the individual's medical record .Individual care plans shall address, to the extend possible .Time frames and parameters for monitoring and reassessment . On 4/10/24 at 3:40 PM, the survey team met with the Administrators and DON and discussed the concern of the facility staff failing to follow the care plan intervention and RD recommendations to weigh Resident #2 weekly. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/10/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. Building B. Wing	04/10/2024

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 28567 Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for 2 of 19 residents, Resident #31 and #63. The findings included: 1. For Resident #31, the facility staff failed to provide ADL care. Resident #31's fingernails were observed to be long with debris present. Resident #31's diagnoses included, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side. Section C (cognitive patterns) of Resident #31's annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/08/24 included a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15 points. Section GG (functional abilities and goals) was coded to indicate Resident #31 was dependent (1) in the area of personal hygiene. On 04/08/24, during initial tour of the facility Resident #31's fingernails on both hands were observed to be long with debris present. On 04/09/24 at 8:58 a.m., during an observation of Resident #31 with the Director of Nursing (DON). The DON acknowledged Resident #31's fingernails were long and had debris present. The DON stated they would get someone to cut the residents nails. On 04/09/24 at 3:00 p.m., during an end of the day meeting with the Administrator and DON the issue with Resident #31's fingernails was reviewed. On 04/10/24 at 12:34 p.m., the Administrator provided the survey team with documentation indicating an in-service was provided to the facility staff regarding nail care. Sixteen employees had signed this form. No further information regarding this issue was provided to the survey team prior to the exit conference. 34307 2. For Resident #63, the facility staff failed to provide nail care. Resident #63's face sheet listed diagnoses which included but not limited to Parkinsonism, hypertension, and encounter for palliative care. Resident #63's most recent minimum data set with an assessment reference date of 03/11/24 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that that the resident is cognitively intact. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #63's comprehensive care plan was reviewed and contained a care plan for Resident will have assistance as needed to complete toileting, bathing, dressing, grooming, to maintain dignity. Interventions for this care plan included Assist resident with grooming: brush teeth, denture care, comb hair, glasses, dentures, hearing aids . Surveyor spoke with Resident #63 on 04/09/24 at 10:55 am. Surveyor observed resident's fingernails to be long and discolored. Surveyor asked Resident #63 if nails being long bothers them and Resident #63 stated, Yes, and I have asked where or when I can get them cut. I also asked where I can get my hair cut. Surveyor spoke with Resident #63 on 04/10/24 at 8:30 am and resident showed surveyor his hands, and stated, they finally cut my nails. The concern of Resident #63's nails being long and discolored was discussed with the administrator and director of nursing on 04/09/24 at 3:15 pm. Administrator provided the surveyor with an in-service education form regarding nail care dated 04/10/24 on 04/10/24 at 11:00 am. No further information provided prior to exit.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42353 Based on staff interview and clinical record review, the facility staff failed to follow the medical provider orders for 1 of 19 residents in the survey sample, Resident #62. The findings included: For Resident #62, the facility staff failed to administer the medication, Questran on two separate occasions. Resident #62's diagnosis list indicated diagnoses, which included, but not limited to Adult Failure to Thrive, Fecal Abnormalities, Dementia, Paroxysmal Atrial Fibrillation, and Chronic Pain. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/31/24 assigned the resident brief interview for mental status (BIMS) summary score of 13 out of 15 indicating the resident was cognitively intact. Resident #62's clinical records included a 3/26/24 hospice nurse progress note which read in part Upon entering patient's room I noted that patient, clothing and bed linens were covered in a brown substance. The patient stated it was a mixture of Boost and diarrhea .Staff report that patient has multiple episodes of diarrhea each day and that Imodium was ineffective. MD notified and order received for antidiarrheal, see medication order this date . Resident #62's medical provider orders included an order dated 3/26/24 for Questran 4-gram oral powder mix in 8 ounces fluid and administer by mouth every Monday, Wednesday, and Friday for diarrhea. A review of Resident #62's March 2024 and April 2024 Medication Administration Records (MARs) revealed the Questran was not administered on 3/29/24 due to awaiting pharmacy and 4/03/24 due to not available pending pharmacy. On 4/09/24 at 4:31 PM, surveyor spoke with the pharmacy representative (PR) regarding Resident #62's Questran delivery. PR stated the order was received by the pharmacy on 3/26/24 at 5:43 PM and a 22-day supply was delivered to the facility the same day between 10:00 PM to 11:00 PM. PR stated the medication was delivered in powder form in a tin container. PR stated the facility sent in an order on 4/04/24 requesting a refill in packet form. On 4/09/24 at 4:55 PM, surveyor observed Resident #62's Questran packets located in the medication cart with a pharmacy delivery date of 4/04/24. On 4/10/24 at 2:31 PM, surveyor spoke with Registered Nurse (RN) #1 who stated they did not administer the Questran on 3/29/24 because it was not in the facility. The survey team met with the Administrators and Director of Nursing (DON) on 4/10/24 at 3:40 PM and discussed the concern of Resident #62 not receiving Questran as ordered on 3/29/24 and 4/03/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495386	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON returned to the surveyor on 4/10/24 at 5:31 PM with an unopened tin container of Questran powder and stated they had located it on the wrong medication cart. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/10/24.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 22218 Based on staff interview and clinical record review, facility staff failed to provide treatment as ordered for pressure ulcers for 2 of 19 residents in the survey sample (Residents #68 and #35). Resident #68 was admitted to the facility with diagnoses including, but not limited to, hypertension, seizures, pressure ulcers, pain, anxiety, and depression. On the most recent Minimum Data Set assessment, the resident scored 15/15 on the brief interview for for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The electronic clinical record contained orders for daily dressing changes to a sacral wound. The Treatment Administration Record was blank for 4/4/2024. The nursing progress note dated 4/4/2024 at 2:10 AM documented the resident refused a shower at that time but agreed to a bed bath. There were no wound care notes on that date. The surveyor asked to speak with the wound care nurse about missed treatments on 4/8/2024, but was not able to speak with the nurse. The administrator and director of nursing were made aware of the concern on 4/10/2024. Resident #35 was admitted to the facility with diagnoses including but not limited to amputation above the knee, hypertension, pressure ulcers of right and left hip and sacrum, and malignant neoplasm of liver and colon. On the most recent Minimum Data Set assessment the resident scored 0/15 on the Brief Interview for Mental Status and was assessed with continuous signs of delirium including inattention and disorganized thinking. The electronic clinical record contained orders for daily dressing changes to a stage 3 sacral wound. The Treatment administration records for March and April 2024 contained multiple blanks, which the Director of Nursing told surveyors was generally an indication that treatments were not completed. The surveyor was able to establish that the majority of the blanks were on days the treatment nurse had assessed or completed treatments. The surveyor was unable to find evidence of treatments completed on 4/5 and 3/15/2024. The administrator and director of nursing were notified of the remaining concern during a summary meeting on 4/10/2024.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34307 Based on staff interview, clinical record review and facility document review the facility staff failed to complete a safe smoking assessment for 1 of 19 residents, Resident #20. The findings included: For Resident #20, the facility staff failed to complete a safe smoking assessment when resident was admitted to the facility. Resident #20's face sheet listed diagnoses which included but not limited to hemiplegia and hemiparesis following cerebral infarction, dementia, Alzheimer's disease, and nicotine dependence. Resident #20's most recent minimum data set with an assessment reference date of 02/09/24 assigned the resident a brief interview for mental status score of 5 out of 15 in section C, cognitive patterns. This indicates that that the resident is severely cognitively impaired. Resident #20's comprehensive care plan was reviewed and contained a care plan for Resident will smoke safely at designated areas at scheduled times through next review. Interventions for this care plan include Safe smoking screen completed on admission and as needed. During entrance conference, survey team requested a list of residents in the facility that currently smoke. Resident #20 was included on this list. Resident #20's clinical record contained a nurse's progress note dated 02/02/24 which read in part, Resident arrived at the facility at approximately 12PM in private vehicle from home accompanied by two family members .Resident does smoke and will need to be evaluated for smoking safety . Resident #20's clinical record was reviewed, and surveyor could not locate a safe smoking assessment. On 04/09/24 at 3:15 pm, surveyor informed administrator and director of nursing (DON) that a safe smoking assessment for Resident #20 could not located be in clinical record. On 04/10/24 at 9:20 am, DON provided surveyor with a copy of a safe smoking assessment for Resident #20 dated 02/02/24 and stated, We did a late entry for the assessment. Surveyor requested and was provided with a facility document entitled Smoking Policy-Residents which read in part, 1. Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. The concern of completing a safe smoking assessment upon admission was discussed with the administrator and director of nursing on 04/10/24 at 3:50 pm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 28567 Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide the health care provider ordered therapeutic diet for 2 of 19 residents, Resident #54 and #25. The findings included: 1. For Resident #54, the facility staff failed to provide the health care provider ordered Magic Cup. Resident #54's diagnoses included, but were not limited to, Parkinson's disease and dysphagia. Section C (cognitive patterns) of Resident #54's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/07/24 included a Brief Interview for Mental Status (BIMS) summary score of 14 out of a possible 15 points. Resident #54's comprehensive care plan included the area of nutrition. Goals included diet as ordered. Resident #54's clinical record included a provider order for a Magic Cup three times a day with trays. Order date 03/11/24. On 04/09/24 at 8:30 a.m., the surveyor observed Resident #54's breakfast meal. Resident #54 was observed with chocolate ice cream on their meal tray. The surveyor did not observe a Magic Cup on this meal tray. 04/09/24 at 9:31 a.m., the Dietary Manager stated they had been out of Magic Cups for the last 2 weeks and they were substituting with Magic Shakes. The surveyor did not observe a Magic Cup or a Mighty Shake with Resident #54's breakfast meal on 04/09/24. On 04/09/24 at 1:45 p.m., Resident #54 was asked if they received a Magic Cup with meals, they were unable to answer this question. On 04/09/24 at 1:48 p.m., during an interview with Certified Nursing Assistant (C.N.A.) #1 this staff stated they had not seen a Magic Cup on the residents meal trays for a while. A review of Resident #54's Medication Administration Records (MARs) revealed that for the month of April 2024 the facility nursing staff were documenting the Magic Cup had been provided and were documenting the percentage the resident consumed. For 04/03/24 for the breakfast meal there was no documentation on the MAR to indicate the Magic Cup had been provided the administration block was blank. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/09/24 at 2:10 p.m., Licensed Practical Nurse (LPN) #4 was asked about the Magic Cup and stated they saw what they thought was a Magic Cup. LPN #4 stated it was in a clear container and there was a small amount of chocolate around the cup. On 04/07/24 for the evening meal LPN #4 documented Resident #54 had consumed 100% of their Magic Cup. The resident's tray ticket that accompanied the lunch meal on 04/09/24 indicated this Resident received ice cream and a Magic Cup with each meal. On 04/09/24 at 3:00 p.m., during a meeting with the Administrator and Director of Nursing (DON) the issue with the Magic Cup not being on the residents meal tray and the nursing staff documenting that it had been provided was reviewed. The Administrator stated Magic Cups were backordered and they were substituting with Mighty Shakes. On 04/10/24 at 4:57 p.m., the DON provided the surveyor with a copy of a progress note timed and dated after the breakfast meal on 04/09/24 indicating the provider had been notified the Magic Cups were on back order and a new order was obtained to supplement with Mighty Shakes. The DON was asked if the MAR had a hole in an administration block what would this mean. The DON stated it could mean various things and gave examples of the nursing staff may have forgotten to document, item not available, not administered, or an omission. No further information regarding this issue was provided to the survey team prior to the exit conference. 34307 2. For Resident #25 the facility staff failed to ensure the provider ordered supplement Magic cup was available. Resident #25's face sheet listed diagnoses which included but not limited to type 2 diabetes mellitus, dysphagia, and dementia. Resident #25's most recent minimum data set with an assessment reference date of 03/22/24 assigned the resident a brief interview for mental status score of 6 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Resident #25's comprehensive care plan was reviewed and contained a care plan for Maintain adequate nutritional status. Interventions for this care plan include Diet as ordered, encourage compliance with ordered diet. Resident #25's clinical record was reviewed and contained a physician's order summary which read in part, Magic cup with meals. Resident #25's electronic medication administration record for the month of April 2024 was reviewed and contained an entry which read in part, Magic cup with meals. This entry was initialed as being administered as ordered. On 04/09/24 at 8:35 am, surveyor observed licensed practical nurse (LPN) #3 checking Resident #25's breakfast meal tray. LPN #3 stated, I need to go get her a magic cup. LPN #3 stopped a kitchen staff in the hallway and asked them to get a magic cup for Resident #25. Kitchen staff stated We don't have magic cups. I'll have to go next door to get one. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/09/24 at 9:30 am during an interview with the dietary manager, they stated that the facility food vendor has been out of magic cup for the last two weeks, and they have been substituting mighty shakes. Surveyor observed Resident #25's breakfast meal tray and it did not contain a mighty shake. Surveyor spoke with Resident #25 on 04/09/24 at 10 am regarding magic cups and mighty shakes. Surveyor asked resident if they had been getting either a magic cup or a mighty shake on their meal tray, and Resident #25 stated, I don't think so. Resident #25's clinical record was reviewed and contained a Nutrition Quarterly form dated 04/02/24 which read in part, Quarterly Progress Summary: . with quarterly f/u (follow up). Wt. (weight) trending down; 4.6# (pounds) in 3 months, not significant at this time. Receiving magic cup with meals, Glucerna BID (twice daily) provided by family per orders . The concern of not providing magic cup with meals was discussed with the administrator and director of nursing on 04/09/24 at 3:30 pm. On 04/10/24 the director of nursing provided the surveyor with a nurse's progress note which read in part, 4/9/2024 10:38 AM NP (nurse practitioner) . (name omitted) gave order that states may hold magic cups and supplement with mighty shakes until off back order. Rp (responsible party) made aware. No further information was provided prior to exit.

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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. 42353 Based on resident interview, staff interview, and clinical record review, the facility staff failed to obtain a provider ordered medication for 1 of 19 residents in the survey sample, Resident #46. The findings included: For Resident #46, the facility staff failed to obtain Alaway eye drops (antihistamine eye drops used to provide temporary relief for itchy eyes due to ragweed, pollen, grass, animal hair and dander) as ordered by the provider. Resident #46's diagnosis list indicated diagnoses, which included, but not limited to Acute Follicular Conjunctivitis, Chronic Pain Syndrome, Open-Angle Glaucoma, Type 2 Diabetes Mellitus, Schizophrenia, and Congestive Heart Failure. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/12/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. On 4/08/24 at 1:11 PM, while speaking with Resident #46, surveyor noted redness of the right eye and underneath the eye. When asked the cause of the redness, Resident #46 stated their eye was itchy and they had been waiting 18 days for the medication to arrive. Resident #46's clinical record included a 3/25/24 family nurse practitioner (FNP) progress note which read in part .Patient presents today with right eye redness and itching .Allergic conjunctivitis of both eyes .Redness of right eye .Itch of right eye .Plan: Alaway with drops in each eye daily x 2 weeks . According to Resident #46's March 2024 and April 2024 Medication Administration Records (MARs), the Alaway was only signed as being administered once (4/01/24) between 3/26/24 through 4/05/24 due to being unavailable/awaiting pharmacy. On 4/09/24 at 4:33 PM, surveyor spoke with the pharmacy representative (PR) who stated Alaway was an over the counter (OTC) medication and the facility had chosen to have the pharmacy send OTC medications only if pre-approved by the facility Director of Nursing (DON). PR stated the order was received by the pharmacy on 3/25/24 at 4:30 PM but was never sent by the pharmacy. PR stated a facility nurse contacted the pharmacy on 3/29/24 inquiring why the Alaway had not been delivered and was informed it was due to the medication being an OTC medication requiring DON approval. DON approval was never received by the pharmacy and the order was for a limited duration and automatically discontinued on 4/05/24 per the provider order. PR stated when an OTC medication was ordered, the nurses need to know to notify the DON because the pharmacy does not automatically notify the facility for DON approval. On 4/09/24 at 4:38 PM, surveyor spoke with the DON and requested evidence indicating the facility provided Alaway for Resident #46. DON stated they would check the shipping manifest. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 1:10 PM, surveyor spoke with licensed practical nurse (LPN) #7 who signed the MAR indicating administration of the Alaway on 4/1/24. LPN #7 stated they did not administer the Alaway on 4/01/24 due to it not being available and had signed the MAR in error. According to the clinical record, Resident #46 received a new order for Ketotifen 0.025% one drop in both eyes once daily for irritation on 4/05/24 and received the first administration on 4/06/24. On 4/10/24 at 3:40 PM, the survey team met with the Administrators and DON and discussed the concern of staff failing to obtain Resident #46's Alaway eye drops. The DON returned to the surveyor on 4/10/24 at 5:08 PM and stated they had not been able to find where Alaway had been purchased by the facility. Surveyor then spoke with the Administrator who agreed there had been a delay in receiving the ordered Alaway for Resident #46. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/10/24.

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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. 34307 Based on staff interview, clinical record review and facility document review the facility staff failed to review and act upon a monthly medication regimen review for 1 of 19 residents, Resident #234. The findings included: For Resident #234 the facility staff failed to follow-up on pharmacy recommendation from the monthly medication regimen review. Resident #234's face sheet listed diagnoses which included but not limited to type 2 diabetes mellitus. Resident #234's most recent minimum data set with an assessment reference date of 02/17/24 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #234's comprehensive care plan was reviewed and contained a care plan for Resident is as risk for complications associated with hyper or hypoglycemia related to: diabetes on insulin therapy. The director of nursing (DON) provided the survey team with a list of residents who had a medication regimen review with recommendations for the month of February 2024. Resident #234 was on this list. Resident #234's clinical record was reviewed on 02/09/24. Surveyor could not locate a medication regimen review/recommendation form in the clinical record. Surveyor informed the DON on 04/10/24 that they could not locate a pharmacy recommendation form in the clinical record. On 04/10/24 at 3:15 pm, the DON provided the surveyor with copy of a Note to Attending Physician/Prescriber form from the pharmacy, dated 02/21/24, which read in part, This resident is currently receiving: 1) Lantus 30 units BID (twice daily). 2) Jardiance 25 mg QD (every day). 3) Humalog SSI (sliding scale insulin) QID (four times daily). Recent blood glucose levels have been elevated. Please consider increasing Lantus to a total dose of 32 units BID. This form had not been signed by the physician/provider. Resident #234's clinical record contained a physician's order summary for the month of March 2024 which read in part, insulin glargine (Lantus) (U-100) 100 unit/ml (3 ml) subcutaneous pen: subcutaneous twice daily. give 30 units in the morning and 30 units before bedtime. Resident #234's blood glucose levels were reviewed and indicated that blood glucose levels continue to be elevated with an average of 300. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and was provided with a facility policy entitled Medication Regimen Reviews which read in part, 1. The Consultant Pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication. 8. Within 24 hours of the MRR, the Consultant Pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. 11. If the Physician does not provide a timely or adequate 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. 15. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. The concern of not reviewing and/or acting upon a pharmacist recommendation was discussed with the administrator and DON on 04/10/24 at 3:40 pm. No further information provided prior to exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42353 Based on observation, staff interview, and facility document review, the facility staff failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility kitchen and 2 of 2 nourishment rooms. The findings included: 1. In the facility kitchen, staff failed to maintain the correct concentration of sanitizing solution in the low temperature sanitizing dish machine and stacked (nested) wet pans together. On [DATE] at 12:40 PM, during the initial kitchen tour, surveyor observed dietary staff washing pans in the dish machine. The Dietary Manager (DM) stated the dish machine was a low temperature machine using a chemical sanitizer. The DM tested the dish machine final rinse chemical sanitizer concentration using a chlorine test strip; however, the test strip did not change color to indicate the presence of sanitizing solution. The DM retested the solution with another dish machine cycle, however, the test strip failed to change color. The DM stated they would contact the dish machine service provider and staff would use Styrofoam serving trays and all other items would be sanitized using the three-dip sink until corrected. At 12:55 PM, surveyor notified the Administrator of the concern regarding the dish machine. On [DATE] at 2:59 PM, the Memory Care Administrator approached the surveyor and stated a new container of sanitizing solution had been installed and the dish machine was now working properly. At 3:01 PM, surveyor observed the DM test the dish machine again using a chlorine test strip which indicated the presence of 50 ppm (parts per million) with the final rinse. Surveyor observed a form titled Dish Machine Log located outside the dish room which indicated the dish machine was tested at Breakfast on [DATE] and staff documented a checkmark in the column titled PPM*. The Dish Machine Log included the statement Manufacturer Recommended PPM: ____, however the line to record the recommended PPM was left blank. On [DATE] at 10:46 AM, surveyor spoke with the Dietary Aide (DA) who stated they tested the dish machine on the morning of [DATE] and the sanitizing solution was okay, and the test strip had changed color. Surveyor then spoke with the DM who stated staff record a checkmark on the Dish Machine Log if the sanitizer tested okay. The DM stated they would add the recommended PPM on the log in the designated area. Surveyor requested and received the facility policy titled Dishwashing Machine Use which read in part .4. Dishwashing machine chemical sanitizer concentrations and contact times will be as follows: Type of Solution Chlorine Minimum Concentration ,d+[DATE] ppm . On [DATE] at 10:43 AM, surveyor observed a wire shelving unit with multiple stacks of stacked (nested) pans. At the surveyor's request, the DM separated individual pans from three separate stacks and found water droplets between five pans. The DM stated staff would re-wash the pans and allow them to dry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 3:40 PM, the survey team met with the Administrator, Memory Care Administrator, and the Director of Nursing and discussed the concern of the dish machine failing to have the correct concentration of sanitizing solution and the presence of wet stacked pans in the facility kitchen. No further information regarding these concerns were presented to the survey team prior to the exit conference on [DATE]. 2. Nourishment room refrigerators located on the Blue Ridge and Alleghany nursing units contained multiple unlabeled and/or undated food items. On [DATE] at 10:25 AM, surveyor observed the following items in the Alleghany Nourishment Room refrigerator: an open, undated package of sliced deli turkey, three undated plastic grocery bags tied closed, an undated pizza box, and an undated Styrofoam take-out tray. On [DATE] at 10:31 AM, surveyor observed the following items in the Blue Ridge Nourishment Room refrigerator: an unlabeled/undated take-out container with a meat and bean mixture and two additional undated take-out containers. The freezer contained a half full cup of ice cream with a spoon sticking out of the lid without a label or date, a cup with a frozen brown substance without a label or date, and an unlabeled open cup of ice. On [DATE] at 10:35 AM, surveyor informed the Dietary Manager (DM) of the above observations. The DM stated the kitchen staff checks the temperature of the nourishment room refrigerators daily and discards expired items. Surveyor requested and received the facility policy titled Foods Brought by Family/Visitors which read in part . Food brought by family/visitors that is left with the resident to consume later will [sic] labeled and stored in a manner that is clearly distinguishable from facility-prepared food . On [DATE] at 3:40 PM, the survey team met with the Administrator, Memory Care Administrator, and the Director of Nursing and discussed the concern of the multiple unlabeled and/or undated food items in the Nourishment Room refrigerators. No further information regarding this concern was presented to the survey team prior to the exit conference on [DATE].

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42353 Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a complete and accurate clinical record for 2 of 19 residents in the survey sample, Resident #46 and #21. The findings included: For Resident #46, the facility staff failed to document a change in the resident's condition resulting in an acute care hospital admission. Resident #46's diagnosis list indicated diagnoses, which included, but not limited to Acute Follicular Conjunctivitis, Chronic Pain Syndrome, Open-Angle Glaucoma, Type 2 Diabetes Mellitus, Schizophrenia, and Congestive Heart Failure. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/12/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. On 4/08/24 at 1:11 PM, surveyor spoke with Resident #46 who stated they were sent to the hospital in December after being sick for three to four days. The resident stated upon arrival at the hospital their temperature was 104.5 and they were positive for flu, RSV (Respiratory Syncytial Virus), COVID, and pneumonia. Resident #46's was seen by the family nurse practitioner (FNP) on 12/29/23, the progress note read in part . Patient seen today due to staff reporting patient is noted with cough, congestion, vomiting, and has complaints of nausea .Plan: 2 view chest x-ray due to cough and congestion. Mucinex 600 mg twice daily x 1 week for cough and congestion. Albuterol nebulizer twice daily x 3 days . A nursing progress note dated 12/29/23 at 2:14 PM read in part New orders noted per [name omitted] NP to obtain 2 view chest x-ray, start Mucinex bid [twice a day] x 1 week, albuterol nebulizer treatment x 3 days for c/o [complaints of] cough . The next progress note was dated 1/06/24 at 3:51 AM and read in part Rsd [resident] readmitted after being treated at hospital for Flu . Surveyor was unable to locate facility documentation following the 12/29/23 2:14 PM nursing progress note indicating the change in the resident's condition and resulting transfer to the hospital. On 4/09/24 at 3:06 PM, the survey team met with the Administrator and Director of Nursing (DON) and requested any additional documentation related to Resident #46's change in condition and hospital discharge in December. However, no additional documentation was provided. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received the facility policy titled 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 condition shall be documented in the resident's medical record . No further information regarding this concern was presented to the survey team prior to the exit conference on 4/10/24. 22218 2. For Resident #21, facility staff failed to monitor the resident's weight as ordered. Resident #21 was admitted to the facility with diagnoses including, but not limited to, congestive heart failure (CHF), hypertension, gastroesophageal reflux disease, and fall with fracture. On the most recent Minimum Data Set assessment the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The the electronic clinical record contained an order dated 3/12/24 for weights 3 times per week to monitor CHF status. The electronic medical record (EMR) did not contain three weights per week. The surveyor asked the administrator and director of nursing (DON) about weights during a summary meeting on 4/9/2024. On 4/10, the director of nursing offered a print-out from the EMR titled Vital Signs Grid which listed weights recorded between 3/12 and 4/8. On 4/10/2024 at 9 AM the surveyor noted the resident's EMR weights/vitals section documented 2 weights on 4/10/24. The surveyor asked the resident if she had been weighed that morning. The resident stated she had not. The surveyor asked if she had been weighed the day before or the day before that. The resident said no, they weighed her about once per week. The surveyor spoke with LPN #3, who showed the surveyor the weights and vitals binder with a page for each day. There were weights on 4/3, 4/4, and 4/8. None were recorded on 4/10/2024 page. From the date of the order, there were weights in the EMR on 3/12, 3/13, 3/20, 3/25, 3/29, 4/1, 4/2, 4/3, 4/5, 4/8, and 4/10. The binder where staff documented weights and vital signs daily had weights on 4/3, 4/4, and 4/8. There was a 7 day gap without weight from 3/13 through 3/20; The next 7 day period had 1 recorded weight on 3/25. The surveyor discussed the reliability of the weights recorded in the EMR. The DON stated the nurses explained documenting weights on 4/10 when the resident had not been weighed filling in holes in the EMR.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure a Quality Assurance and Performance Improvement (QAPI) Program to meet the needs of the facility and failed to monitor and revise as needed the plan of correction for the standard recertification surveys dated 4/11/19, 5/27/21, and 2/16/23 in order to maintain compliance as evidenced by repeated deficiencies in the area of Pharmacy Services. The findings included: The area of Pharmacy Services was previously cited with the 4/11/19, 5/27/21, and 2/16/23 standard surveys due to failure to provide evidence of the attending medical provider reviewing and acting upon monthly drug regimen reviews completed by the pharmacist. This deficiency was cited again on the current standard survey dated 4/10/24 due to failure to provide evidence of the attending medical provider review and action taken upon monthly drug regimen reviews completed by the pharmacist for 1 of 5 residents reviewed. On 4/10/24 at 2:45 PM, surveyor met with the Administrator to review the facility QAPI Program. The Administrator stated QAPI meetings were held at least quarterly where facility statistics were reviewed for trending and action plans were developed as indicated. Surveyor discussed the concern of drug regimen reviews being cited on the previous three standard surveys. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/10/24.