STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. BUILDING _____ B. WING _____	C 10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE	600 FULLWOOD LANE MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event S4TR11.	F 000		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to provide an adaptive drinking cup for 1 of 1 visually impaired resident (Resident # 110). The findings included: Resident #110 was admitted to the facility on 07/23/15 with diagnoses which include macular degeneration, atrial fibrillation, hypertension, diabetes, hearing loss and history of falls. The admission Minimum Data Set (MDS) dated 08/03/15 indicated Resident #110 was alert and oriented with no cognitive deficits, and the resident had visual impairment. The MDS further revealed that Resident #110 required supervision with walking, dressing and personal hygiene, but was independent with eating, requiring set-up help only for each meal. The clinical summary of the occupational therapy evaluation dated 09/08/15, indicated the " patient requires decreased assistance with self-feeding with use of red plate and cup and full tray set up to compensate for visual deficits. " A review of Resident #110 ' s medical record revealed a physician ' s order written on 09/08/15 at 8:15 AM for " red plate and cup for all meals to compensate for visual deficits." This was	F 369	Carrington is committed to providing the highest level of care for our residents. Carrington Place¿s response to this report of survey does not denote agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are filing the POC because it is required by law. FTAG 369 Assistive Devices/ Eating Equipment / Utensils: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Assistive device i.e. red cup was provided to Resident #110 on 10/7/2015 at dinner and ongoing. 2. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice The Director of nursing completed an	11/5/15

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

Electronically Signed | 10/30/2015

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 369	Continued From page 1 communicated to dietary by a written dietary communication notification on 09/09/15 that stated " red plate and cup for all meals. " Observations of Resident #110 eating 3 different meals in his room revealed there was a tray card on each occasion noting the use of a red plate and a red cup. Observed meals were as follows: · On 10/06/15 at 5:21 PM dinner tray had red divided plate but no red cup · On 10/07/15 at 8:41 AM breakfast tray had red divided plate but no red cup · On 10/07/15 at 12:36 PM lunch tray had red divided plate but no red cup An interview was completed with Resident #110 on 10/06/15 at 5:21 PM. Resident stated that he was legally blind because of an eye condition and was supposed to have this red cup at meal time, but he hadn ' t had it in over 2 weeks. The Director of Nursing (DON) was interviewed on 10/07/15 at 1:59 PM. DON verified he was not aware Resident #110 had not been receiving prescribed adaptive equipment. DON acknowledged his expectation that staff would follow the physician ' s order for the use of adaptive equipment for residents. A 2nd interview was completed with Resident #110 on 10/07/15 at 5:12 PM. Resident was asked how he felt about not having his red cup. Resident stated that the glass was kind of a brownish color that he can ' t see very well on his table.	F 369	audit of adaptive equipment with MD orders on 10/15/2015 prior to dinner and ensured all adaptive equipment were provided during dinner and ongoing for meals as ordered. The adaptive equipment audit and list was crossed referenced to the meal ticket by the DON and Dietary manager on 10/7/2015. It was noted that all meal tickets were current and no corrections were needed. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur All dietary line staff and nursing staff serving trays will be educated on checking meal tickets and ensuring adaptive equipment is available on tray with each meal as ordered. Ongoing education will be completed on or by 11/5/2015. The Dietary Manager will educate Dietary staff; the DON/SDC will educate the nursing staff. Dietary Line Staff will ensure availability of adaptive equipment using the meal ticket and will notify Dietary Supervisor or Manager as needed. Nursing staff serving tray will check meal ticket and ensure availability of adaptive equipment upon serving tray and will notify Nursing Supervisor or Manager as needed. 4. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained. Director of Nursing / designee will keep a	

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F 369	Continued From page 2	F 369	current list/ log and audit of all residents with adaptive equipment as ordered by MD. This log will be reviewed weekly and updated as needed. The RN Manager / designee assigned to each unit will audit at least one meal a day daily to ensure compliance. The Director of Nursing / designee will audit at least once a week and randomly during different meal times for compliance. The DON will report compliance to Administrator at least weekly x 90 days.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to be sure food preparation equipment was free of debris with 19 of 19 large baking sheet pans. Findings included: During review of the kitchen on 10/7/2015 at 9:10 AM, 11 large sheet pans were observed drying in the area of the dishwasher. The Dietary Manager	F 371	FTAG 371 Food Procure, Storage / Prepare/ Serve- Sanitary 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice All baking sheets were replaced with brand new baking sheets on 10/7/2015 at 12 noon.	11/5/15

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F 371	Continued From page 3 indicated the sheet pans had been cleaned and were drying before being stored on racks. A black substance was observed under the rim of each pan. When questioned about the black substance, the Dietary Manager said it was, "years of baked on stuff" and instructed one of the kitchen staff to take the pans outside spray them with an oven cleaner. Kitchen review on 10/7/2015 at 9:58 AM, revealed the large baking sheet pans were stacked upside down on a rack and ready for use. Examination revealed 19 sheet pans and all had the black substance under the tray's rim. The substance was approximately 1/8 to 1/4 inch deep, was hard in some areas and soft in other areas, and extended all the way around the underside of the rim of the baking sheet pans. During an interview on 10/8/15 at 10:05 AM, the Dietary Manager indicated the baking sheets should be clean. She stated that staff had tried to clean them on 10/7/2015 but could not remove all the debris from under the rims so new baking sheets would have to be purchased. On 10/8/15 at 2:01 PM, the Administrator stated it was her expectation that all equipment in the kitchen be clean.	F 371	2. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice All Baking equipment and utensils were inspected on 10/7/20156 by Certified Dietary Manager. All other equipment and utensils met cleanliness and all are in good repair. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur A log has been initiated on 10/8/2015 by the Certified Dietary Manager. This log will be completed to audit sheet pans for cleanliness and good repair at least 3x a week by the Certified Dietary Manager / designee. 4. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained. Monthly cleaning schedule has been revised to include all baking pans for cleanliness and good repair. This log will be submitted to the Administrator by the Certified Dietary Manager at least weekly for review of compliance. Integrate with QAPI: Administrator and Certified Dietary Manager will inspect kitchen monthly x 90 days and report compliance to QAPI	

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F 371	Continued From page 4	F 371	committee at least quarterly x 2 quarters. 5.Include dates when corrective action will be completed Corrective Action will be completed by 11/5/2015	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		11/5/15

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F 431	Continued From page 5 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to discard expired medications for 1 of 4 medication rooms (400 unit medication room). Findings included: An observation on 10/06/15 at 11:52 AM revealed 2 outdated medications in the 400 unit medication storage cabinet. Each medication had been opened and individually labeled with the name of a resident who currently resided in the facility. The medications included the following: · Travoprost 0.004% eye drops. The eye drops were opened on 08/15/14. The expiration date was 03/2015 on the plastic bottle and on the box it was packaged in. · Select Women's Premium multivitamin. The label on the plastic bottle indicated it was best if used by 11/2014. Review of the Night Shift Duties for nurse's policy, night shift nurses are responsible to " check carts, fridge and cupboards for medications that need to be returned to pharmacy to be discarded. " A staff interview with the Director of Nursing (DON) on 10/06/2015 at 2:27 PM revealed that the Nurse Manager makes weekly checks for expired medications on all the carts and medication rooms on weekends. The DON stated the trend with most medications is they are used before the expiration date and expired medications are returned to the pharmacy for	F 431	FTAG 431 Drug Records, Label Store Drugs & Biologicals 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice The Director of Nursing returned expired meds to the pharmacy on 10/06/2015. 1:1 re-education of the 11-7 Nurse Manager was done by the DON on 10/06/2015 on handling expired medication procedure. 2. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice The DON/ADON and 7-3 RN Manager inspected all medication rooms and cabinets for expired medications on 10/6/2015. No other expired medications were noted unreturned to the pharmacy. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur Re-education on all Licensed Nursing Staff by DON/SDC on handling expired medication procedures will be completed	

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F 431	Continued From page 6 disposal. The DON acknowledged his expectation was that expired medications be removed from the medication storage areas.	F 431	by 11/5/2015. a) Pharmacy Consultant will audit and inspect monthly for compliance in returning expired medication to pharmacy. b) 7-3 RN Mangers will inspect medication rooms daily to ensure return of all expired medications timely. c) DON / designee will check medication room for expired medications at least weekly and randomly for compliance 4. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained. DON will submit compliance report to Administrator weekly x 90 days. Integrate with QAPI: Weekly and Monthly reports will be submitted for review of compliance to QAPI committee at least quarterly x 2 quarters. 5. Include dates when corrective action will be completed Corrective Action will be completed by 11/5/2015	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		11/5/15

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F 520	Continued From page 7 assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: The Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitoring of these interventions put into place on 12/2014. This deficiency was originally cited on a recertification survey 12/2014 and subsequently recited 10/2015 on the current recertification survey. The deficiency was in the area of Dietary Services-Food procurement; Store/Prepare/Serve-Sanitary. The continued failure of the facility during two federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assurance program. Findings include: This tag is cross referred to F371 Dietary	F 520	FTAG 520 QAA Committee- Membership/ Meet Quarterly/ Plans 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice On 10/22/2015 QAPI met and discussed PoC for F371. QAPI committee members will closely monitor list of specific areas with repeat citation from 2014-2015 recertification survey results. 2. Address how corrective action will be	

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F 520	Continued From page 8 Services 10/2015. Based on observations and staff interviews the facility failed to be sure food preparation equipment was free of debris with 19 of 19 large baking sheet pans. The facility was cited for F371 during the 12/2014 recertification survey. The facility failed to remove 1 of 3 outdated gallons of milk in the walk in refrigerator, failed to discard 1 of 1 outdated buttermilk in the reach in refrigerator, failed to label 2 of 2 large plastic bags of salad mix in the walk in refrigerator and failed to date and label 1 of 1 frozen bags of food product in the walk in freezer. An interview was conducted with the administrator on 10/8/2015 who reviewed their QA process, committee members, frequency of meetings and subcommittee meetings. The Administrator indicated that they had addressed the issues cited 12/2014 by sending 7 staff to ServSafe classes and were planning to send 7 more staff. They had monitored the labeling of food products and monitored for expirations dates on food products and there was improvement. The current deficiency identified had not been addressed or monitored in POC from the 12/2014 deficiency or specifically identified as an issue by the QA committee.	F 520	accomplished for those residents having the potential to be affected by the same deficient practice Using the State Health Department¿s Food Establishment Inspection Report checklist as a tool, QAPI facilitator will assign members to an assigned area of responsibility to inspect at least weekly x 90 days. The completed report will be submitted to the Administrator weekly x 90 days and a monthly compliance report to QAPI committee quarterly x 4. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur Dietary Supervisor and cooks will continue to inspect daily. The Certified Dietary Manager will inspect at least weekly and ongoing. The Certified Dietary Manager will report to Administrator compliance weekly x 90 days and then monthly thereafter. Certified Dietary Manager and Administrator will inspect kitchen monthly x 3 months and Administrator will check at least randomly and quarterly thereafter. Integrate with QAPI: Compliance reports will be submitted and monitored by QAPI at least quarterly x 4 4. Include dates when corrective action will be completed Corrective action will be completed by 11/5/2015	

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to provide a Medicare Non-Coverage letter and rights to appeal for 1 of 3 sampled residents who were discharge from Medicare services (Resident #210). The findings include:

1. A record review of the Notice of Medicare Provider Non-Coverage form revealed Resident #210 was not provided notification of Medicare Non-Coverage by the facility and given the right to appeal. The facility was not able to verify through documentation that Resident #210 received notification of Medicare Non-Coverage in writing.

An interview with the Social Worker on 10/08/15 at 11:35 AM stated she was responsible for providing the Medicare Non-Coverage notices to residents and families. During the interview, she stated Resident #210 should have been notified at least a few days prior to ending of Medicare services and given the right to appeal. She further stated the expectation was for Medicare Non-Coverage forms to be issued timely and residents given the right to appeal.

Interview with the Administrator on 10/08/15 at 1:50 PM stated the expectation was for Medicare Non-Coverage notices to be provided to residents prior to the ending of the Medicare services to notify residents of their right to appeal.