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 03/17/2020

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 03/09/2020 through 03/17/2020. The facility was found in compliance with requirement CFR 483.73, Emergency Preparedness. Event ID # 4FL211.	E 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a safe environment by repairing an electrical cord with twist on wire connectors for one of one observed drain chemical pump (at the three compartment sink in the kitchen) and failing to have a non-combustible covered ash receptacle in one of two designated smoking areas (employee smoking area). Findings included: 1. An observation conducted in the kitchen on 3/9/20, which started at 9:25 AM, revealed a time activated chemical pump utilized to dispense drain maintenance chemicals. The pump was observed to have a power cord which was observed to have been repaired with two twist on wire connectors and then wrapped in electrical tape. The repaired cord connected the pump to a	F 689	Carrington Place 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. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) 483.25(d) Accidents. The facility must ensure that - 483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and 483.25(d)(2)Each resident receives	4/3/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/02/2020

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.

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wall outlet and was observed to have been on the tiled floor next to the wall.

A second observation conducted in the kitchen on 3/11/20, which started at 11:09 AM, revealed a time activated chemical pump utilized to dispense drain maintenance chemicals. The pump was observed to have a power cord which was observed to have been repaired with two twist on wire connectors and then wrapped in electrical tape. The repaired cord connected the pump to a wall outlet and was observed to have been on the tiled floor next to the wall.

A third observation conducted in the kitchen in conjunction with an interview with the Assistant Dietary Manager (ADM) and the Maintenance Director was conducted on 3/12/20, which started at 10:26 AM. The observation revealed a time activated chemical pump utilized to dispense drain maintenance chemicals. The pump was observed to have a power cord which was observed to have been repaired with two twist on wire connectors and then wrapped in electrical tape. The repaired cord connected the pump to a wall outlet and was observed to have been on the tiled floor next to the wall. The ADM stated she was unaware the power cord for the pump had been repaired using twist on wire connectors and stated she would notify the Maintenance Director. When the Maintenance Director arrived, he stated he was also unaware the power cord, which connected the pump to a wall outlet, had been repaired using twist on wire connectors and electrical tape. He said it was not the correct way to repair the cord and the correct way was to replace the whole cord from the plug which went to the wall outlet to the pump. He stated neither he nor someone from the facility maintenance

F 689

adequate supervision and assistance devices to prevent accidents.

Chemical Pump:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice?

All repairs and maintenance of the chemical pump are performed by the chemical pump company. This chemical pump undergoes routine service by the company. Facility maintenance staff do not perform repairs on the chemical pump. The facility maintenance supervisor contacted the company servicng the chemical pump, on 3/14/2020, regarding the power cord modifications performed on the chemical pump. The electrical cord was replaced with one single cord going from the pump to the electrical outlet, on 3/14/2020.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

The maintenance department conducted a full facility inspection of all electrical outlets and power supplies within the facility dietary department, laundry department and environment department. No further issues identified.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not

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department had repaired the power cord for the pump with the twist on wire connectors. He further stated the facility did not handle the maintenance of the pump and believed the company who serviced the chemicals also serviced the pumps and it was that company who had made the repair. He stated he would contact the company immediately so the power cord could be properly repaired.

During an interview conducted on 3/12/20 at 2:21 PM with the Administrator he stated he believed it was the contractor who had made the repair to the power cord to the pump. He further stated the maintenance department of the facility conducted no electrical repairs.

A phone interview was conducted on 3/17/20 at 11:41 AM with a service technician from the company who produced the time activated chemical pump utilized to dispense drain maintenance chemicals. He stated the pump had not been manufactured with twist on wire connectors to splice the power cord. He said twist on wire connectors were an inappropriate and unsafe repair for the power cord. He stated a proper repair would have been to replace the power cord with one single cord from the pump to the plug which goes into the wall outlet.

2. An observation was conducted of the employee smoking area on 3/10/20 at 3:18 PM. The smoking area was observed to be at the end of hallway on the 200 unit and was accessed by an exit door next to room 205. The following was observed at the smoking area: a non-metal trash can with a domed top and hinged doors which had a plastic trash can liner in it, 2 brown plastic chairs, 1 white plastic chair, 2 small round black

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recur and indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

The maintenance department will perform QA safety inspections on appliances requiring electrical cords appliances Maintenance supervisor will turn in QA Safety Inspections weekly x 4 weeks, monthly x 3 months, then quarterly for 2 quarters thereafter. Compliance will be reported by the maintenance supervisor to the Administrator and Leadership Committee monthly x 90 days and to the QAPI Committee x 4 quarters. QAPI committee will determine further actions if necessary.

Trashcan in Employee Smoking Area:

The facility has 2 smoking areas outside of the 200 hall; a Resident Smoking area, which already had a non-combustible covered receptacle to deposit cigarette butts and ashes, and am Employee smoking area, which had a non-metal trash can with domed top and hinged doors. Completed by 4/3/2020

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The facility removed the non-metal trash can with domed top and hinged doors from the employee smoking area and replaced it with a non-combustible covered receptacle to deposit cigarette

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metal tables, and 2 melamine round ash trays with cigarette butts in them.

A second observation was conducted of the employee smoking area on 3/11/20 at 8:57 AM. The smoking area was observed to be at the end of hallway on the 200 unit and was accessed by an exit door next to room 205. The following was observed at the smoking area: a non-metal trash can with a domed top and hinged doors which had a plastic trash can liner in it, 2 brown plastic chairs, 1 white plastic chair, 2 small round black metal tables, and 2 melamine round ash trays with cigarette butts in them.

An interview was conducted with Housekeeper #1 on 3/11/20 at 8:59 AM at the employee smoking area. She stated the employee smoking area was utilized by not just employees who smoke but also residents who smoke. The housekeeper stated cigarettes were allowed to burn out in the ash tray and then were dumped into the trash can at the smoking area, the housekeeper gestured and pointed toward the non-metal trash can with a domed top and hinged doors. The housekeeper stated there was no other container to deposit the cigarette butts and ashes into beside the trash can she pointed to.

A third observation was conducted of the employee smoking area on 3/12/20 at 11:04 AM in conjunction with an interview with the Maintenance Assistant (MA). The smoking area was observed to be at the end of hallway on the 200 unit and was accessed by an exit door next to room 205. The following was observed at the smoking area: a non-metal trash can with a domed top and hinged doors which had a plastic trash can liner in it, 2 brown plastic chairs, 1 white

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butts and ashes into. Completed by 4/3/2020

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice

The facility currently has only 2 residents that smoke. Both residents were interviewed on 3/17/2020. When asked if they ever smoke in the employee smoking area, they both replied no..

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The facility removed the non-metal trash can with domed top and hinged doors from the employee smoking area and placed a non-combustible covered receptacle to deposit cigarette butts and ashes into in its place. The resident smoke area already had a non-combustible covered receptacle to deposit cigarette butts and ashes into. Completed by 4/3/2020.

The facility instituted a revised policy regarding approved receptacles in employee AND resident smoking area(s). Facility will only permit non-combustible covered receptacle to deposit cigarette butts and ashes into moving forward.

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F 689	Continued From page 4	F 689		

plastic chair, 2 small round black metal tables, and 2 melamine round ash trays with cigarette butts in them. The MA stated there was not a non-combustible covered receptacle to deposit cigarette butts and ashes into. He further stated typically housekeeping was the department responsible for ordering items such as the receptacle to deposit ashes and cigarette butts into.

A fourth observation was conducted of the employee smoking area on 3/12/20 at 11:04 AM in conjunction with an interview with the Housekeeping Director (HD). The smoking area was observed to be at the end of hallway on the 200 unit and was accessed by an exit door next to room 205. The following was observed at the smoking area: a non-metal trash can with a domed top and hinged doors which had a plastic trash can liner in it, 2 brown plastic chairs, 1 white plastic chair, 2 small round black metal tables, and 2 melamine round ash trays with cigarette butts in them. The HD stated there was not a non-combustible covered receptacle to deposit cigarette butts and ashes into. She further stated her employees would not put cigarette butts and ashes into the trash can which was at the smoking area. She stated she would order a non-combustible covered receptacle to deposit cigarette butts and ashes into.

During an interview conducted on 3/12/20 at 2:21 PM with the Administrator he stated he did not believe cigarette butts and ashes were being deposited into the trash can and he felt that if the cigarette butts were extinguished and deposited into the trash can with the liner it was not a violation.

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F 693	Continued From page 5	F 693		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to flush a resident ' s feeding tube before or after the administration of a liquid protein supplement and failed to store a tube feeding syringe with the plunger separated from the syringe for 1 of 1 sampled resident reviewed for feeding tube (Resident #72). Findings included: Resident #72 was admitted to the facility on 12/20/2018 with diagnoses to include hemiplegia	F 693	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) 483.25(g)(4)-(5) Enteral Nutrition 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The resident's G-tube was assessed by RN manager to ensure patency. Staff nurse received re-education by RN	4/3/20

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after a stroke, dysphagia (difficulty swallowing) and gastrostomy (feeding tube). The most recent annual Minimum Data Set assessment dated 1/30/2020 assessed Resident #72 to be cognitively intact and to receive less than 501 calories per day by feeding tube.

1. The facility policy "Administering medication through feeding tubes (no date) was reviewed and the policy stated, in part: "Flush the tube with 30 milliliters (ml) of room temperature water ... prior to administering medications ... flush tube with 30 ml of room temperature water at the end of all medication administration."

A physician order dated 12/20/2018 for liquid protein (supplement) 30 ml by feeding tube three times per day.

There was no order to flush the feeding tube before or after the liquid protein supplement.

The administration of Resident #72 ' s liquid protein by his feeding tube was observed on 3/11/2020 at 12:10 PM with Nurse #2. Nurse #2 diluted the resident ' s liquid protein with water, inserted the syringe and poured the diluted liquid protein into the syringe. Nurse #2 allowed the liquid protein to infuse by gravity into the feeding tube and then she disconnected the syringe and closed the feeding tube. Some of the liquid protein was noted to remain in the feeding tube. Nurse #2 did not flush the feeding tube before administering the liquid protein or after administering the liquid protein.
Nurse #2 was interviewed on 3/11/2020 at 12:21 PM. Nurse #2 reported Resident #72 received the liquid protein by feeding tube at 8:00 AM, 1:00 PM and 8:00 PM. Nurse #2 reported she had

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manager on 3/11/2020 on administration of medications via G-tube.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- All residents that receive medications and, or, liquid protein via G-tube were identified using the facility EHR software. 7 total residents receive medications via G-tube.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- The DON provided re-education to all nursing staff on administration of medications and, or liquid protein via G-tube on 3/30/2020.
- The facility developed a QA monitoring tool/log for "enteral medication administration"
- Staff nurses will be observed at random, by RN manager or SDC nurse, demonstrating proper enteral medication administration RN managers.
- Observations will be recorded on the monitoring logs
- On a weekly basis x 4 weeks, a monthly basis x 4 months, on a quarterly basis x 2 quarters then annually thereafter.

4. Indicate how the facility plans to monitor its performance to make sure that

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administered the liquid protein at 8:00 AM and had flushed the tubing before and after the administration. When asked why she had not flushed the tube during the observation, Nurse #2 reported she was nervous and had forgotten. Nurse #2 reported she was not aware there was not an order to flush the feeding tube before and after the liquid protein.

The Director of Nursing (DON) was interviewed on 3/12/2020 at 11:35 AM. The DON reported Nurse #2 was nervous during the observation and had realized she had administered the liquid protein incorrectly as soon as she completed the task. The DON reported she had not observed Nurse #2 administering medications by feeding tube, but a pharmacy consultant had observed her administer medications by feeding tube on 7/31/2019 and no issues were observed. The DON reported an in-service was schedule for 3/26/2020 for all nursing staff regarding medication administration by feeding tube. The DON reported that it was her expectation that feeding tubes were flushed before and after medications.

The Administrator was interviewed on 3/12/2020 at 2:08 PM. The Administrator reported it was his expectation that feeding tubes were flushed before and after medication administration.

2. The administration of Resident #72 ' s liquid protein by his feeding tube was observed on 3/11/2020 at 12:10 PM with Nurse #2. The feeding tube syringe was noted to be stored in a plastic bag with the date 3/11/2020 marked on it. There were visible drops of water in the tip of the feeding tube syringe. The feeding tube syringe was noted to have the plunger inserted into the

F 693

solutions are sustained; and

- The Director of Nursing will ensure compliance and monitor logs on a weekly basis x 4 weeks, a monthly basis x 4 months, on a quarterly basis x 2 quarters then annually thereafter
- Compliance will be reported by the DON to Administrator x 3 months and to the QAPI committee x 2 quarters. Further recommendations will be determined by the QAPI committee based on data.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- The nurse received re-education by RN manager on 3/11/2020 and proper storage of tube feed syringes

2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- All residents that receive medications and, or, liquid protein via G-tube were identified using the facility EHR software. 7 total residents receive medications via G-tube.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- The DON provided re-education to all nursing staff on the proper storage of tube

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F 693	Continued From page 8 syringe. Nurse #2 removed the syringe from the plastic bag and used the syringe to administer the liquid protein supplement. Nurse #2 rinsed the syringe and replaced the plunger into the syringe and placed the syringe in the plastic bag. There were visible drops of water in the tip of the feeding tube syringe. Nurse #2 was interviewed on 3/11/2020 at 12:21 PM. Nurse #2 reported Resident #72 received the liquid protein by feeding tube at 8:00 AM, 1:00 PM and 8:00 PM. Nurse #2 reported she had administered the liquid protein at 8:00 AM using the syringe she used for the 1:00 PM administration. Nurse #2 reported she had put the plunger back into the syringe at 8:00 AM. Nurse #2 reported she was aware she should not have put the plunger back into the syringe after rinsing the syringe out, but she was nervous. The Director of Nursing (DON) was interviewed on 3/12/2020 at 11:35 AM. The DON reported Nurse #2 was nervous during the observation and had realized she had stored the tube feeding syringe incorrectly soon as she completed the task. The DON reported an in-service was schedule for 3/26/2020 for all nursing staff regarding medication administration by feeding tube. The DON reported that it was her expectation that feeding tubes syringes were stored with the plunger separated from the syringe. The Administrator was interviewed on 3/12/2020 at 2:08 PM. The Administrator reported it was his expectation that feeding tubes syringes were stored correctly.	F 693	feed syringes. Re-education completed by 3/30/2020. • The facility developed a QA monitoring tool for “Tube Feed Syringe Storage” • Staff nurses will be observed at random demonstrating proper storage of tube feed syringes, by RN managers, and or SDC nurse during random observations. • Observations will be recorded on the monitoring logs • On a weekly basis x 4 weeks, a monthly basis x 4 months, on a quarterly basis x 2 quarters then annually thereafter. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and • The Director of Nursing will ensure compliance and monitor logs on a weekly basis x 4 weeks, a monthly basis x 4 months, on a quarterly basis x 2 quarters then annually thereafter • Compliance will be reported by the DON to Administrator x 3 months and to the QAPI committee x 2 quarters. Further recommendations will be determined by the QAPI committee based on data.	
F 761	Label/Store Drugs and Biologicals	F 761		4/3/20

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F 761 SS=E	Continued From page 9 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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 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 observations, record review and staff interviews, the facility failed to maintain a medication refrigerator temperature within a range (36-46 degrees Fahrenheit (°F)) recommended by the manufacturers' of medications stored in 1 of 4 medication refrigerators (100 Hallway); failed to label insulin vial with opened date and/or expiration date; failed to label saline irrigation solution and large plastic irrigation syringe with a resident name and	F 761	Tag 0761 - 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals (LONG TERM CARE FACILITIES) 483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory	

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"open date"; failed to dispose of a box of expired protein supplement powder with 14 doses left in 1 of 8 medication carts.

Findings included:

On 03/12/20 at 10:30 AM a review of the March 2020 refrigerator temperature log located in the medication storage room on the 100 hall revealed that all 6 temperatures noted through 3/11/20 were below the acceptable range of 36-46 degrees °F and 4 days had no temperature recorded. Recorded temperatures were 34°F on 03/02/20, 30°F on 03/03/20, 32°F 03/05/20, 30°F on 03/07/20, 30°F on 03/08/20 and 34°F on 03/10/20. March 1, 4, 6, and 9 had no temperatures recorded. The following medications were in the refrigerator that required the medication storage range to be 36-46°F per the medication packaging: 2 Lantus insulin pens, 3 Trulicity insulin pens, 2 Lorazepam 30 ml bottles.

The temperature of the medication refrigerator in the 100 Hallway Medication Room on 03/12/20 at 01:45 PM was 30 °F. This was verified by Nurse #2.

On 03/12/20 at 10:52 AM an inspection of the 4 medication carts for the 100 and 200 halls was completed with the Unit Manager (UM #1). In the medication cart for rooms 111-122, opened and unlabeled patient care supplies were found in the medication cart drawer. This included an opened irrigation syringe in a plastic container and a partially full bottle of 250cc saline found in the medication cart drawer. UM #1 stated she did not know why it was there. Nurse #2 stated these supplies were used for suprapubic catheter or

F 761

and cautionary instructions, and the expiration date when applicable.

1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

All items identified during the surveyor inspection were corrected by 3/12/2020. Facility reviewed medication receiving log from 2/14/2020 and contacted the nurse that received the Levemir insulin on 2/14/2020. Nurse clarified the date written on the insulin container, was the open date. Nurse stated (she) does not label the vials when she opens the insulin bottles, she only labels the pharmacy label on the medication. Corrections were made immediately to the unlabeled vial. Nurse received immediate re-education. Completed 3/12/2020

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

All medication carts and cabinets were inspected for proper labeling of medications and dates of by DON on 3/12/2020. No further issues identified.

All medication carts were audited by Administrator on 3/12/2020 for proper labeling of insulin. All insulin vials and bottles were dated. Administrator interviewed 2 nurses on 100 hall, 2 nurses on 200 hall, 2 nurses on 300 hall and 2 nurses on 400 hall. Each nurse stated the label the insulin vials and bottles when

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F 761	Continued From page 11 gastrostomy tube irrigation. On 3/12/20 at 11:15 AM a review of the medication cart on the 200 hallway was completed with UM #1. A box of protein supplement powder with 14 packets was found with the manufacturer expiration date of 12/25/19. The box had an "open date" of 03/06/20 written on it in black marker. Also, on the 200 hallway medication cart, it was noted that a plastic container, with a Levemir insulin vial inside. A date of 02/14/20 was written on the plastic container. No dates were present on the insulin vial. The date of 02/14/20 on the plastic container did not specify if it was the opened date or the expiration date. An interview with Nurse #3 was done on 03/12/20 at 11:20 AM regarding the expired protein supplement. She stated when the protein supplement was taken from the medication stock in the medication room supply cabinet, the expectation was that they checked for the expiration date. An interview with the Director of Nursing (DON) was done on 03/12/20 at 11:35 AM regarding the unlabeled insulin, expired medication, refrigerator temperature logs and temperatures and the open saline flush and irrigation supplies. She stated if the label was on the box or bottle, it would be nice if the date was on the medication vial. She stated that they should make sure the date that was labeled was clear as to whether it was the "open date" or the expiration date. She stated that the refrigerator temperature should be checked every night and recorded, staff should have checked the expiration date on the protein supplement box	F 761	they are opened with the OPEN DATE. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? 1. An Insulin Vial Check Sheet was developed and added to Medication Count sheet binder on each nursing cart. The On-coming nurse and Out going nurse are to check all insulin for proper labeling and sign the Insulin Vial Check at change of shift. Nursing signature on the log indicates that the checks were completed. 7-3 RN managers will check the monitoring log daily during the 7-3 shift. Check sheets will be turned into the DON weekly. 2. An Expired Medication QA Log was developed and added to the Medication Count Sheet Binder on each nursing cart. All medication carts and medicine cabinets will be inspected nightly by 11-7 staff nurses. Staff nurses to document inspection on the monitor log. 11-7 manager to ensure completion of the logs daily during 11-7 shift. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained? The Director of Nursing will ensure compliance and monitor logs daily for the next 90 days then every week x 60 days ; and then every other week x 30 days. Compliance will be reported by the Director of Nursing to the Administrator x	

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F 761	Continued From page 12	F 761		

when it was opened and the opened saline and syringe should not have been on the cart.

On 03/12/20 at 1:59 PM an interview with the DON was done regarding the medication refrigerator in the 100 hallway, and the temperature reading of 30°F and thick ice that was in the freezer section inside the refrigerator. The DON stated her expectation that maintenance would be notified when the temperature is out of range.

An interview with the Administrator on 03/12/20 at 02:44 PM was conducted. He stated that his expectation for the medication storage areas was that staff would follow policies and the regulations, and medications would be stored within date, insulin vials were dated correctly, patient care items were in the appropriate place and medication refrigerators were checked and within the correct temperature range.

90 days and to the QAPI Committee x 2 quarters. Further actions will be determined by the QAPI committee.

483.45(h) Storage of Drugs and Biologicals
¿483.45(h)(1) 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

Medication Refrigerator Temperature Controls:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
Medication storage refrigerators noted during survey were inspected by maintenance on 3/12/2020. Ice build-up was removed and correct temperature settings were set.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

All other medication storage refrigerators were inspected by maintenance personnel for proper temperature controls, ice build-up and function. No other issues identified. Completed on 3/12/2020

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F 761	Continued From page 13	F 761	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Facility updated QA temperature log form for the medication storage refrigerators on 3/12/2020. Additions to the QA medication refrigerator log indicate parameters 36-46F of temperature requirements and instructions for the steps to take when temperature measurements are not within appropriate parameters. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained New temperature log will be completed daily by 11-7 charge nurse following inspecting temperature settings. 11-7 RN Manager will ensure that the monitor logs are completed daily. The Director of Nursing will ensure compliance the next 90 days, then every week x 60 days ; and then every other week x 30 days. Compliance will be reported by the Director of Nursing to the Administrator x 90 days and to the QAPI Committee x 2 quarters. Further actions will be determined by the QAPI committee.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		4/3/20

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F 812	Continued From page 14 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain a safe temperature in one of four nourishment room/nurses ' station refrigerators (300 Hall Nurses ' Station), failed to maintain food service equipment without a debris build up on two of four pieces of cookline equipment (deep fat dryer and convection oven) observed for cleanliness, failed to maintain a level of quaternary ammonia between 200 to 400 parts per million in two of two sanitizer buckets checked for sanitizer level, failed to secure facial hair for one of two employees observed assisting in food preparation, and failed to allow food plates, bases, and covers to air dry prior to assemblage and stacking for three of three observations. Findings Included: 1. A review of a document titled, Quality Assurance (QA) of Nourishment Rooms, for the	F 812	Food Procurement,Store/Prepare/Serve-Sanitar y CFR(s): 483.60(i)(1)(2) 483.60(i) Food safety requirements. Maintain a safe temperature in one of four nourishment room/nurses ' station refrigerators (300 Hall Nurses ' Station) 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Refrigerator on 300 hall was inspected by maintenance staff on 3/12/2020. The facility temperature tested 3 different liquids in the refrigerator and all were reading temperatures of 38 degrees, yet the thermometer was reading 48 degrees.	

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F 812	Continued From page 15	F 812		

300 Hall Nurses ' Station, for March 2020, was completed on 3/12/20. The document showed a recorded temperature greater than 40 degrees for seven of the eleven days recorded for the month, 3/2/20-44 degrees, 3/4/20-42 degrees, 3/5/20-44 degrees, 3/6/20-44 degrees, 3/9/20-44 degrees, 3/10/20-46 degrees, and 3/11/20-50 degrees (all measurements in Fahrenheit). All temperature readings were initialed by Nurse #1.

An observation of the refrigerator at the 300 Hall Nurses ' Station refrigerator, conducted on 3/10/20 at 11:29 AM, revealed the thermometer inside of the refrigerator read 48 degrees Fahrenheit. The refrigerator was utilized to store resident food including, but not limited to the following perishable food items: milk, opened containers of apple sauce, juice containers, and yogurt.

An observation of the refrigerator at the 300 Hall Nurses ' Station refrigerator, conducted on 3/11/20 at 4:17 PM, revealed the thermometer inside of the refrigerator read 48 degrees Fahrenheit. The refrigerator was utilized to store resident food including, but not limited to the following perishable food items: milk, opened containers of apple sauce, juice containers, and yogurt.

An observation of the refrigerator at the 300 Hall Nurses ' Station refrigerator, conducted on 3/12/20 at 8:27 AM, revealed the thermometer inside of the refrigerator read 50 degrees Fahrenheit. A closer observation of the refrigerated perishable items revealed the following: 3 packs of sour cream, 4 butter packets, 3 containers of apple sauce, 2 opened one quart containers of nutritional supplement, 1

A new thermometer was placed in refrigerator and the new thermometer read 38 degrees. The previous thermometer was faulty and was thus replaced.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Revisions were made to the current QA Nourishment Log form on 3/12/2020. The form now indicates appropriate ranges 36-46F of temperature parameters and state instructions for steps to take when temperature measurements are not within appropriate parameters. Completed 3/13/2020.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur and indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

New temperature log will be completed daily by 11-7 charge nurse and checked by 11-7 RN Manager daily. Copies of the completed form will be submitted to the administrator on a weekly basis for 4 weeks, on a monthly basis for 3 months, on a quarterly basis for 12 months.

The results of the temperature logs will be reviewed during QAPI on a quarterly basis for 12 months. Further actions will be determined by the QAPI committee.

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F 812	Continued From page 16 opened 1.4 quart container of opened thickened water, 34 4 ounce orange juice containers, 9 4 ounce apple juice containers, 1 4 ounce carton of 2% milk, 4 4 ounce yogurt containers, 1 4 ounce container of sliced watermelon, and 2 containers of cottage cheese/blueberry combination packages. An interview was conducted on 3/12/20 at the conclusion of the kitchen observation which started at 10:26 AM with the Assistant Dietary Manager (ADM). She sated if a nurse observed the temperature in a refrigerator at one of the nurses ' stations or nourishment rooms to be more than 40 degrees the nurse should inform her or maintenance department. An interview was conducted with the Maintenance Director of 3/12/20 at 11:45 AM and he stated he had not been informed nor was he aware of any work orders regarding the temperature for the refrigerator at the 300 Hall Nurses Station. The Maintenance Director added, the refrigerator at the 300 Hall Nurses ' Station was new and it was unlikely there was anything wrong with it. During an interview conducted on 3/12/20 at 12:04 PM, with the Director of Nursing, she stated if the refrigerator temperature was observed to be greater than 40 degrees Fahrenheit, it was her expectation for the nurse who observed and recorded the temperature to report the temperature to her and the maintenance director/maintenance department. An interview was conducted with the administrator on 3/12/20 at 2:21 PM. He stated the temperature in the refrigerators which store food should be 40 degrees or less. He further	F 812	Failed to maintain food service equipment without a debris build up on two of four pieces of cookline equipment (deep fat dryer and convection oven) observed for cleanliness 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Both pieces of equipment were deep cleaned on 3/15/2020 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential for being affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Kitchen staff received re-education by the Food Service Director on 3/16 on the requirements to clean the cooking appliances before the end of each shift. Logs have been developed for daily documentation and accountability of cleanliness of the appliances 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained	

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F 812	Continued From page 17 explained he believed there was a possibility the thermometer was not working correctly, and it was stuck at 50 degrees. He said they had replaced the thermometer into the refrigerator. He said he would have expected if a reading was discovered of the thermometer in a refrigerator to have been above 40 degrees then the employee should have used a thermometer to check the actual temperature of the perishable products in the refrigerator. He continued, if the temperature was above 40 degrees then the employee should refer to the policy of Food Storage for the Nourishment Rooms. During a phone interview conducted on 3/12/20 at 5:19 PM with Nurse #1 she stated she had recorded the refrigerator temperature as 50 degrees Fahrenheit on 3/11/20 while she was on the 11:00 PM to 7:00 AM shift starting on 3/11/20. She explained it had been a busy night and she had not had a chance to notify anyone regarding the temperature of the refrigerator. She said she should have notified the supervisor, or she should have written a work order regarding the refrigerator temperature of 50 degrees. She further stated she had documented the other temperatures which had exceeded 40 degrees Fahrenheit but believed she did not have to notify anyone as long as the temperature was 46 degrees Fahrenheit or less. 2. Observations of the kitchen conducted on 3/09/20 at 9:25 AM, 3/11/20 at 11:09 AM, and 3/12/20 at 10:26 AM revealed a buildup of grease on the right side of the deep fat fryer and the left side of the convection oven. An interview and observation were conducted with the Assistant Dietary Manager (ADM) on	F 812	Logs will be monitored daily by the Food Service Supervisor and the Dietary Cooks on the weekends x 90 days. The Food Service Supervisor will ensure compliance and monitor logs daily for the next 90 days then every week x 60 days ; and then every other week x 30 days. Compliance will be reported by the Food Service Supervisor to Administrator x 90 days and to the QAPI Committee x 2 quarters. Failed to maintain a level of quaternary ammonia between 200 to 400 parts per million in two of two sanitizer buckets checked for sanitizer level 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Food Service Supervisor emptied the sanitizer bucket and refilled it with correct concentration of solution on 3/11/2020. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 812	Continued From page 18 3/12/20 at 10:26 AM. The ADM stated it was her expectation for the kitchen equipment, including the deep fat fryer and the convection oven, to be clean and free of grease/debris buildup. When the ADM observed the deep fat fryer and the convection oven, she stated they did not appear to be clean and were both in need of being cleaned. An interview was conducted with the administrator on 3/12/20 at 2:21 PM. He stated he expected for the kitchen equipment to be reasonably cleaned and when he had observed the deep fat fryer and the convection oven, he stated it appeared as if they had not been recently cleaned. 3. During a kitchen observation conducted on 3/11/20, which started at 11:09 AM, Dietary Aide #3, who had unrestrained facial hair, was observed pouring 15 cups of iced tea and placed covers on them. He was also observed putting a pan of uncooked Brussels sprouts into the steamer oven while not wearing a beard guard to restrain facial hair. An interview was conducted on 3/12/20 at the conclusion of the kitchen observation which started at 10:26 AM with the ADM. She sated the facility had beard guards available to restrain facial hair and when an employee who had facial hair was actively preparing food, that individual should wear a beard guard. An interview was conducted with the administrator on 3/12/20 at 2:21 PM. He stated he expected for dietary staff who had facial hair and were active in the process of food preparation to have their facial hair restrained.	F 812	recur; The dietary staff will increase change out the solution in the sanitizer buckets mid-shift instead of daily. The concentration will be checked by Food Service Supervisor, and or designee at that time and the concentration will be recorded on a monitoring log. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Logs will be monitored daily by the Food Service Supervisor and the Dietary Cooks on the weekends x 90 days. The Food Service Supervisor will ensure compliance and monitor logs daily for the next 90 days then every week x 60 days ; and then every other week x 30 days. Compliance will be reported by the Food Service Supervisor to Administrator x 90 days and to the QAPI Committee x 2 quarters. Failed to secure facial hair for one of two employees observed assisting in food preparation 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; a. The dietary staff member was instructed to put on a hair ne.t was re-educated on facility policy regarding securing facial hair with hair net whenever	

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F 812	Continued From page 19 4. An observation was conducted in the kitchen on 3/9/20, which started at 9:25 AM. During the observation the third bay of the three compartment sink was observed to have had the faucet running water into the sink. The sink was observed to have had a label for sanitizer. The faucet water continued to fill the sink until the water overflowed out of the sink into the second sink, which was labeled as the rinse sink, and onto the flat area of the sink where there was a dish rack and large kitchen items on the rack, including a pot and a baking pan. Dietary Aide (DA) #1 was observed to go over to the sink, turn the faucet off, and dip a green bucket into the third bay of the sink. DA #3 then was observed wiping down two tray carts prior to the carts being taken outside to be washed. The water in the sink was observed to have been clear. During an observation conducted of the kitchen, which started at 11:09 AM on 3/11/20, the ADM was observed to fill a deep well bucket with sanitizer, in the third compartment of the three compartment sink, which was labeled sanitizer. The ADM was then observed washing, rinsing, and sanitizing utensils needed for the steam table to tray foods. The color of the sanitizing solution was observed to be a red color and it was dispensed from a hose which was connected to dispensing unit above another the first and second sinks. During an interview conducted during a kitchen observation on 3/12/20, which started at 10:26 AM, DA #1 stated she had checked the sanitizer level in the bucket after she had dipped the bucket in the sink and the quaternary ammonium (quat) sanitizer level was 200 parts per million	F 812	entering the food service prep area and or preparing food or beverages for residents. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; b. All residents have the potential of being affected 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; c. All dietary staff were re-educated on facility policy regarding securing facial hair with hair net whenever entering the food service prep area and or preparing food or beverages for residents. d. The Food Service Supervisor, and or designee will complete Dietary Uniform QA monitoring Log on all dietary staff prior to any food preparation activities, to ensure staff are wearing appropriate dietary protective garments. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained e. Logs will be monitored daily by the Food Service Supervisor and the Dietary Cooks on the weekends x 90 days. The Food Service Supervisor will ensure compliance and monitor logs daily for the next 90 days then every week x 60 days ; and then every other week x 30 days.	

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Continued From page 20
(ppm).

An interview was conducted in conjunction with an observation with the ADM and Certified Dietary Manager (CDM) during a kitchen observation which started at 10:26 AM on 3/12/20. The ADM was observed checking the quat level in a red bucket of sanitizer which was located by the coffee maker and a red bucket which was located under the steam table. The sanitizer solution had a clear appearance. The quat level was observed to have been 50 PPM in each. The ADM and CDM each stated in order for the quat to effectively sanitize the concentration needed to be in the range of 200-400 PPM. The ADM was then observed disposing of the sanitizer and stated she would fill them with fresh sanitizer. The ADM further stated their process was to fill the sink with sanitizer, test the concentration of the sanitizer solution, and if it was in the 200-400 PPM range, the red buckets were then filled from the sink. She stated there was no need to check the sanitizer concentration in the buckets when using that process.

An interview was conducted with the administrator on 3/12/20 at 2:21 PM. He stated he expected for the sanitizer level to be at the recommended level to sanitize food preparation surfaces and kitchen equipment.

5. An observation of the kitchen was conducted on 3/9/20, which started at 9:25 AM. During the observation, 21 of 21 plates and bases were observed to have been stacked in a nesting manner with moisture between the plates and the bases.

An observation of the kitchen was conducted on

F 812

Compliance will be reported by the Food Service Supervisor to Administrator x 90 days and to the QAPI Committee x 2 quarters.

Failed to allow food plates, bases, and covers to air dry prior to assemblage and stacking for three of three observations.
1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
a. Dietary staff to rewashed all of the plates, bases, and covers on 3/11/2020, letting them air dry afterwards before stacking them in a nesting manner.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

b. All residents had the potential to be affected.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
c. Dietary Staff was re-educated by Food Service Supervisor on facility policy, which states all washed items must be dry prior to stacking items in a nesting manner. Our facility has one designated staff, “pot washer” that washes and a separate designated staff member on the “clean side” that stacks the clean items when dry. The dietary staff member

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 03/17/2020

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 812	Continued From page 21 3/11/20, which started at 11:09 AM. During the observation, 5 of 5 observed plates and bases were found to have been stacked in a nesting manner with moisture between the plates and the bases. The 5 observed plates and bases were used for resident food when the meal was being plated. An observation of the kitchen was conducted on 3/12/20, which started at 10:26 AM, in conjunction with an interview with the ADM and CDM. During the observation, 112 of 112 observed plates and bases were found to have been stacked in a nesting manner with moisture between the plates and the bases. In addition, 106 plate covers were found to have been stacked in a nesting manner with moisture on the covers. The ADM stated the plates, bases, and covers should all have been allowed to air dry prior to being stacked in preparation for meals to be plated. The CDM then directed the dietary staff to rewash all of the plates, bases, and covers. The ADM stated the facility had racks the plate covers and bases could air dry on and an observation was made of the rack and the plate covers and bases were observed to fit on the rack. Upon completion of washing some of the plates, bases, and covers, Dietary Aide (DA) #2 was observed stacking the freshly washed, and still wet with visible moisture, plates and bases. The CDM was then observed instructing DA #2 and other dietary staff to re-wash all of the plates and bases, again, which had just been stacked and allow them to dry prior to stacking them. The CDM stated she would educate the dietary staff on the importance of allowing food service equipment to air dry as part of the sanitation process.	F 812	assigned to the “clean side” will be required to complete Dry Dish QA check on all washed dietary items, to ensure the items are being allowed to dry prior to being stacked. They are to document on a the QA Log. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Logs will be monitored daily by the Food Service Supervisor and the Dietary Cooks on the weekends x 90 days. The Food Service Supervisor will ensure compliance and monitor logs daily for the next 90 days then every week x 60 days ; and then every other week x 30 days. Compliance will be reported by the Food Service Supervisor to Administrator x 90 days and to the QAPI Committee x 2 quarters.	

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 **03/17/2020**

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 812	Continued From page 22 An interview was conducted with the administrator on 3/12/20 at 2:21 PM. He stated he expected for plates, covers, and bases to be allowed to air dry prior to stacking them.	F 812		