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 06/09/2022

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 and complaint investigation survey was conducted on 06/06/22 through 06/09/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #JU3B11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/06/22 through 06/09/22. Event ID #JU3B11. The following intakes were investigated NC00185259, NC00188176, and NC00184109. 4 of the 4 complaint allegations were not substantiated.	F 000		
F 583 SS=F	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		7/4/22

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

Electronically Signed | | 06/30/2022

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.

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 06/09/2022

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 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to respect the residents right to privacy and confidentiality by placing signage on resident's room doors which indicated residents' vaccination status for 8 of 30 resident room doors reviewed for confidentiality. (Rooms 132, 201, 203, 306, 309, 317, 320, 321) The findings included: An observation of the 300 Hall was conducted on 6/6/22 at 3:05 PM. A yellow sign was posted on the door of Rooms 306, 309, 317, 320 and 321. The sign read, "Attention: This room is occupied by a NON-vaccinated COVID-19. During a facility outbreak ...This resident is on quarantine." The signage was visible for the public to see. An observation was conducted of the 100 Hall and 200 Hall on 6/7/22 @11:23 AM. A yellow sign was posted on Rooms 132, 201 and 203. The sign read, "Attention: This room is occupied by a NON-vaccinated COVID-19. During a facility outbreak ...This resident is on quarantine." The signage was visible for the public to see.	F 583	ACKNOWLEDGEMENT DISCLAIMER Carrington Place acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The Plan of Correction is submitted as a written allegation of compliance. Carrington Place's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nordoes it constitute an admission that any deficiency is accurate. Further, Carrington Place reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. F583 SS=F: Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	

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 06/09/2022

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 583	Continued From page 2 An interview was conducted on 6/8/22 at 4:18 PM with the Infection Preventionist. The Infection Preventionist stated that she felt that the signage was a violation of HIPPA (Health Insurance Portability and Accountability Act). The Infection Preventionist stated that she was instructed that the signage was not a violation because of the risk to public safety. An interview was conducted on 6/8/22 with the Administrator. The Administrator stated that he was instructed to place the signage on unvaccinated residents' doors by his corporate office. The Administrator further stated that the signage was placed there to visually identify those residents that had not been vaccinated.	F 583	All items noted during survey were immediately corrected and the facility removed the signage on resident room doors which indicated residents' vaccination status. A facility wide inspection was conducted by infection control preventionist on 6/10/2022. No further residents were affected. Administrator contacted facility President and Vice President on 6/9/2022. The facility requirements to post vaccination status on resident room doors was discontinued. The posting of all infection control signage within Carrington Place is the responsibility of the facility RN Infection Preventionist. On 6/9/2022, the Administrator advised the facility Infection Preventionist of the discontinued requirement to post notices on the doors to unvaccinated resident rooms. Part of the normal daily Infection Preventionist routine includes infection control rounds on each unit to ensure current facility policies are followed. As such, the Infection Preventionist will monitor complaince with revised policy during daily rounds. Corrective Action will be completed on July 4, 2022.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		7/4/22

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 06/09/2022

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 758	Continued From page 3	F 758		

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended

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 06/09/2022

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 758	Continued From page 4 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, Physician interviews, and Pharmacy Consultant interview, the facility failed to ensure Physician's orders for PRN (as needed) psychotropic medications were time limited in duration for 4 of 8 Residents (Resident #36, #62, #67, #80) reviewed for unnecessary medications. The findings included: 1. Resident #62 was admitted to the facility on 7/6/20 with diagnoses that included anxiety disorder and depression. The quarterly Minimum Data Set (MDS) assessment dated for 4/19/22 revealed Resident #62 was severely cognately impaired. She was coded as having 1 to 3 days of rejection of care during the assessment period. Resident #62 was not coded as receiving any PRN psychotropic medications during the assessment period. A careplan was last revised on 6/2/22 for psychotropic medication use due to anxiety and depression. The interventions included to notify Physician of any side effects related to the medication, administer medications as ordered by Physician, and monitor Resident's behaviors.	F 758	F758 Free From Unnecessary Psychotropic Meds/PRN Use It is the practice of Carrington Place that PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for appropriateness of that medication. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The RN manager completed a QA prn psychotropic medication audit on resident(s) #36, #62, #67, #80 and immediately corrected items noted during survey 1. Resident # 62: Physician order dated for 6/2/22 Lorazepam 2miligram (mg)/milliliter (ml) oral concentrate 0.25ml every 4 hours as needed for anxiety. The charge nurse consulted with the resident s physician / prescribing provider. The medication was	

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 06/09/2022

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 758 Continued From page 5

A Physician order dated for 6/2/22 indicated Lorazepam 2miligram (mg)/milliliter (ml) oral concentrate 0.25ml every 4 hours as needed for anxiety was ordered without a stop date.

2. Resident #67 was admitted to the facility on 1/6/20 with diagnoses that included Alzheimer's disease, depression, and anxiety disorder.

The quarterly MDS assessment dated for 4/29/22 indicated Resident #67 was severely cognitively impaired. She was not coded as having any behavioral symptoms or having received any PRN psychotropic medications during the assessment period.

A careplan was last revised on 6/1/22 for the use of PRN psychotropic medications due to anxiety. The careplan included interventions to provide medications as ordered, monitor Resident's behaviors, notify Physician of any abnormal changes in behaviors.

A Physician's order dated for 6/1/22 indicated Lorazepam 2mg/ml oral concentrate 0.5mg every 4 hours as needed for agitation or restlessness was ordered without a stop date.

A telephone interview was completed on 06/09/22 at 9:45 AM with Physician #1. He indicated PRN psychotropic medications were ordered for 14 days. The Physician stated he then reevaluated the Resident and extended the medication for another 14 days or a time frame he felt appropriate. The Physician indicated if he overlooked adding a stop date to the medication order, the pharmacy alerted him to do so when they reviewed the Resident's medications.

F 758

discontinued on 6/11/2022.

2. Resident #67: Physician order dated for 6/1/22 indicated Lorazepam 2mg/ml oral concentrate 0.5mg every 4 hours as needed for agitation or restlessness. The charge nurse consulted with the resident□s physician / prescribing provider. This medication was discontinued on 6/15/2022

3. Resident #80: Physician order dated 5/27/22 for Lorazepam (medication for anxiety) 0.5 milligram (mg) tablet every 4 hours as needed for severe agitation. The charge nurse consulted with the resident□s physician / prescribing provider. This medication was discontinued on 6/9/2022.

4. Resident #36: Physician's order dated 4/29/22 for Lorazepam 2 milligrams (mg)/per 1 milliliter (ml)oral concentrate 0.5 mg by mouth (PO) or sublingual (SL) every 6 hours as needed. The charge nurse consulted with the resident□s physician / prescribing provider. This medication was discontinued on 6/9/2022.

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

A facility wide physician order audit was conducted by the Nurse Management Team on 6/9/2022. All residents with PRN orders for psychotropic medication were reviewed to ensure the physician order limits the duration to 14 days.

1. Residents do not receive PRN

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 06/09/2022

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 758

Continued From page 6

A telephone interview was completed on 06/09/22 at 1:57 PM with the Pharmacy Consultant. She indicated PRN psychotropic medications required an initial 14 day stop date. The Pharmacy Consultant continued to state the Physician then reevaluated the Resident for continued use of the medication and documented the rationale for extending the medication.

An interview was completed on 6/9/22 at 2:46 PM with the Director of Nursing (DON). She indicated it was her expectation that going forward all PRN psychotropic medications have stop dates included in the order.

Findings included:
3. Resident #80 was admitted to the facility on 1/29/19 with diagnoses which included Alzheimer ' s, dementia, and anxiety.

Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 5/6/22 revealed Resident #80 had severe cognitive impairment. Resident #80 was not coded for as needed (PRN) anti-anxiety medication during the assessment period.

A physician order dated 5/27/22 for Lorazepam (medication for anxiety) 0.5 milligram (mg) tablet every 4 hours as needed for severe agitation with no stop date.

During an interview on 6/08/22 at 4:13 pm the Nurse Manager (NM) revealed she was aware Resident #80' s PRN Lorazepam order required a stop date but stated the Nurse Practitioner (NP) did not have a stop date written on order. The NM was unable to state why she did not notify the

F 758

psychotropic drugs unless med is necessary to treat a diagnosed specific condition that is documented in the clinical record
2. PRN orders for psychotropic drugs are limited to 14 days. If order needs to be extended, physician should document their rationale in the medical record and indicate the duration
3. PRN orders for antipsychotic drugs are limited to 14 days. Orders cannot be renewed unless physician evaluates the resident for continued appropriateness of med
4. Nurses receiving new orders for PRN antipsychotic medication must ensure the above is completed.

III. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
The nursing staff recevied re-education by the DNS on 6/10/2022 regarding the following information:
1. Residents do not receive PRN psychotropic drugs unless med is necessary to treat a diagnosed specific condition that is documented in the clinical record
2. PRN orders for psychotropic drugs are limited to 14 days. If order needs to be extended, physician should document their rationale in the medical record and indicate the duration
3. PRN orders for antipsychotic drugs are limited to 14 days. Orders cannot be renewed unless physician evaluates the

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 06/09/2022

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 758	Continued From page 7 NP that a stop date was needed for Resident #80' s PRN Lorazepam. During an interview on 6/09/22 at 10:21 am the NP revealed she normally wrote for a 14-day stop date but did not write it on this order. She stated she wrote the new order on 5/27/22 as it was written previously. The NP stated she expected the nurse to notify her if the stop date was not included on the written order for Resident #80' s PRN Lorazepam. During an interview on 6/09/22 at 2:26 pm the Director of Nursing (DON) revealed the NM was aware the PRN Lorazepam required a 14-day stop date and it was to be entered with the stop date. The DON stated the Nurse Manager was responsible to ensure Resident #80' s Lorazepam order had a 14-day stop date. During an interview on 6/09/22 the Administrator revealed he expected Resident #80' s PRN Lorazepam order to have a stop date. He stated the facility had checks and balances in place and expected the PRN Lorazepam order to be reviewed to ensure a stop date was in place. 4. Resident #36 was admitted to the facility on 1/18/19 with diagnoses that included chronic obstructive pulmonary disease, anxiety disorder, and major depressive disorder. A review of the quarterly Minimum Data Set (MDS) assessment dated 3/17/22 revealed that Resident #36 had moderate cognitive impairment. Resident #36 was coded as receiving an antianxiety medication for seven days of the assessment period.	F 758	resident for continued appropriateness of med 4. Nurse(s) receiving new orders for PRN antipsychotic medication will ensure prescribed orders are limited to 14 days. PRN Psychoactive QA audits have been developed. The RN Nurse Managers will conduct daily reviews of all new medication orders, to identify new PRN psychotropic medication orders. When the RN Nurse Manager observes new prn psychotropic medication orders, the RN Nurse Manager will audit the order to ensure a 14-day stop date is included in the physician order, and the order is correctly entered into the EHR by the receiving nurse(s). All incidences of non compliance with the PRN stop date will be recorded on the PRN Psychoactive QA log by the RN Nurse Manager(s). Included on the QA log, the RN Nurse Manager will document the following: the Date, Resident Name, Medication Ordered, Corrective Action / Corrective Date, and Signature. The PRN Psychoactive QA log will be reviewed weekly by the DNS to ensure corrective actions have been completed. IV. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing will monitor PRN Psychoactive QA logs weekly for 12 weeks and monthly for 6 months. The DNS will present the results of this audit to the Quality Assurance Performance Improvement committee for the next 3	

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 06/09/2022

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 758	Continued From page 8 A Physician's order dated 4/29/22 for Lorazepam 2 milligrams (mg)/per 1 milliliter (ml)oral concentrate 0.5 mg by mouth (PO) or sublingual (SL) every 6 hours as needed without a stop date. During an interview with the Nurse Practitioner on 6/9/22 at 11:10 AM, she revealed that she normally wrote for a 14 day-day stop date but did not write it on this order. The NP stated she expected the nurse to notify her if the stop date was not included. An interview was conducted with the Director of Nursing (DON) on 6/9/22 at 3:01 PM. The DON stated that she expected all PRN psychotropic medications to have a stop date included in the order.	F 758	consecutive QAPI meetings. The QAPI committee can make changes to ensure the facility remains in compliance. The administrator is responsible for implementing the acceptable plan of correction. Corrective action will be completed on 7/4/2022	
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 - §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	F 812		7/4/22

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 06/09/2022

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 9

standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews the facility failed to maintain kitchen equipment clean, and in a sanitary manner to prevent cross contamination by failing to remove excessive ice buildup from 1 of 1 ice cream freezer, clean 1 of 2 hand sinks, maintain 12 of 12 baking sheets free of food debris and maintain 2 of 2 ice machine vents free of dust. The findings included:

During the initial kitchen tour on 6/7/22 at 11:29 AM the ice cream freezer was observed to have a 2inch buildup of ice on the interior. 12 of 12 baking sheets were observed stacked ready for use with a build up of dark dried food debris ¼ inch under the rim.

During an observation on 6/8/22 at 4:03 PM the hand sink located next to the 3-compartment sink was observed. The wall above the hand sink had brown stains and the hand sanitizer dispenser was dirty. The ice cream freezer was observed to have a 2inch buildup of ice on the interior. 2 of the 2 ice machine filters were observed with a buildup of dust.

During a kitchen observation on 6/9/22 at 10:17 AM with the dietary manager the kitchen was observed to be in the same condition.

In an interview on 6/9/22 at 10:36 AM the dietary manager stated she did not post a cleaning schedule; she gave staff a daily list to clean. She indicated she would have staff clean the areas.

F 812

F812 SS=E : Food Procurement, Store/Prepare/Serve- Sanitary
CFR(s): 483.60(i)(1)(2)

1. Failing to remove excessive ice buildup from 1 of 1 ice cream freezer
The position of Carrington Place regarding the process that lead to this deficiency was failure
to follow established facility policy related to food safety requirements.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
The ice cream freezer was dethawed on 6/10/2022

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 by this finding

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 6/10 on the requirements to ensure ice cream freezer is free from ice buildup. Dietary supervisor will perform visual checks on ice cream freezer and record findings on the Dietary QA Monitoring Log, 5xper week for 4

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 06/09/2022

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 10	F 812		

weeks than 3xper week for 2 months. The Dietary Supervisor will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

Dietary supervisor will perform visual checks on ice cream freezer and record findings on the Dietary QA Monitoring Log, 5xper week for 4 weeks than 3xper week for 2 months. The Dietary Supervisor will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance

The Administrator is responsible for implementation of the acceptable plan of correction.

Include dates when corrective action will be completed
7/4/2022

2. Clean 1 of 2 hand sinks
Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Hand sink and surrounding area was thoroughly cleaned.

Address how the facility will identify other

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 06/09/2022

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 11	F 812	residents having the potential to be affected by the same deficient practice; All residents have a potential to be affected by this 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 6/10 on the requirements to clean the hand sinks and surrounding surfaces before the end of each shift. Dietary supervisor will monitor hand sink area for cleanliness daily and document findings on the Dietary: QA monitoring log Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Dietary Supervisor will complete visual inspection of hand sinks daily and complete Dietary QA monitoring log 5xper week for 4 weeks than 3xper week for 2 months. The Dietary Supervisor will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance. Include dates when corrective action will be completed 7/4/2022 The Administrator is responsible for	

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 06/09/2022

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 12	F 812	implementation of the acceptable plan of correction. 3. Maintain 12 of 12 baking sheets free of food debris Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Dietary department to replaced 12 of 12 baking sheets. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential of being affected. 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 6/10/2022 on the requirements of dietary equipment to be clean and free from cooked on debris buildup. . The Dietary Supervisor will complete visual inspection of baking sheets daily and record findings on Dietary QA monitoring log How the facility plans to monitor its performance to make sure that solutions are sustained; and Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Dietary Supervisor will complete visual inspection of baking sheets daily and record findings on	

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 06/09/2022

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 13	F 812	Dietary QA monitoring log 5xper week for 4 weeks than 3xper week for 2 months. The Dietary Supervisor will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance Include dates when corrective action will be completed 7/4/2022 The Administrator is responsible for implementation of the acceptable plan of correction. 4. Ice machine vents must be free of dust Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Vents were cleaned by maintenance staff on 6/9/2022 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential of being affected. 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 6/10/2022 on the requirements to ensure ice machine vents are regularly inspected to	

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 06/09/2022

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 14	F 812	be free of dust. Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Dietary Supervisor will complete visual inspection ice machine air filters weekly and record findings on Dietary QA monitoring log weekly for 12 weeks. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Dietary Supervisor will complete visual inspection ice machine air filters weekly and record findings on Dietary QA monitoring log weekly for 12 weeks. The Dietary Supervisor will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance Include dates when corrective action will be completed 7/4/2022 The Administrator is responsible for implementation of the acceptable plan of correction.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 814		7/4/22

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 06/09/2022

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 814	Continued From page 15 Based on observation and staff interviews the facility failed to maintain 1 of 1 dumpster in good condition that contained waste and was free of leaks. This was evident in 2 of 2 observations of the dumpster. The findings included: An observation on 6/07/22 at 11:11 AM of the dumpster area revealed a leak. The front-end underside of the dumpster was observed with wet sludge underneath the frame. Liquid was observed leaking out, with a build up of black sludge under the frame and on the ground. 3 of the 4 back rollers bars were observed to have paper debris and buildup of black sludge on the dumpster and 1 foot wide on the ground. A second observation of the dumpster on 6/8/22 at 4:24 PM was made with the Administrator. The front-end underside of the dumpster was observed with wet sludge underneath the frame. 5 to 6 flies were observed in the area. Liquid was observed to leaking out, with a buildup of black sludge under the frame and on the ground. 3 of the 4 back rollers bars were observed to have paper debris and buildup of black sludge on the dumpster and 1 foot wide on the ground. In an interview on 6/8/22 at 4:25 PM the Administrator stated the dumpster had recently been repaired and should not leak. He indicated he would call the dumpster company immediately. In an interview on 6/8/22 at 4:28 PM the District Certified Dietary Manager indicated the dumpster should not leak and she would notifiy the maintenance man immediately.	F 814	F814: Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) 483.60(i)(4)- Dispose of garbage and refuse properly. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Facility administration contacted waste management company on 6/8/2022 and requested services to repair compactor at site of leaking. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; No residents have the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; EVS management team received education on requirement to maintain dumpster in good condition and free of leaks. EVS supervisor will perform visual checks on dumpster daily and record visual inspection checks on the Trash Compactor QA monitoring tool. Director of EVS will contact trash compactor company immediately for any observed leaking. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Monitoring of the corrected action to ensure the deficient practice will not reoccur. The EVS Director will present the	

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 06/09/2022

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 814	Continued From page 16	F 814	results of the Trash Compactor QA Monitoring tool to the Administrator every week x 4 weeks, monthly x 3 months and to QAPI committee every on quarterly basis for 6 months. The QAPI committee can make changes to ensure facility remains in compliance. Include dates when corrective action will be completed 7/4/2022 The Administrator is responsible for implementation of the acceptable plan of correction.	