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 02/28/2019

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

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E 000	Initial Comments A recertification survey was conducted 2/24/2019 through 2/28/2019. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID# 9EX611.	E 000		
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation. Event ID 9EX611.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Prognosis for a Hospice resident that was terminally ill for 1 of 3 residents reviewed for Hospice (Resident #12), Percent Intake by Artificial Route for 1 of 3 residents reviewed for Nutrition (Resident #32), Discharge Status for 1 of 3 residents reviewed for Discharge (Resident #134), and Preadmission Screening and Resident Review (PASARR) for 1 of 3 residents reviewed for PASARR (Resident #60). Findings included: Resident #12 was admitted to the facility on 10/12/2015 and readmitted on 3/15/2018. Diagnoses included unspecified dementia with behavioral disturbance, non-displaced intertrochanteric fracture left femur, and muscle weakness. A Hospice contract dated 11/22/2018	F 641	F641. Accuracy of Assessments. PLAN OF CORRECTION: Address how corrective action will be accomplished for those residents found of have been affected by the deficient practice: Section J of the Significant Change MDS assessment for resident #12, dated 11/29/2018, was modified on 2/26/2019 indicating resident had a chronic disease with life expectancy less than 6 months. The Section K portion of the quarterly MDS assessments dated 10/17/18 and 1/2/2019, for resident #32, were both modified on 2/26/2019 to reflect resident's accurate nutritional status. The discharge portion on Section A, of the MDS dated 11/27/2018, for resident #134, was modified on 2/26/2019, to reflect accurate	3/28/19

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

Electronically Signed | 03/21/2019

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F 641	Continued From page 1 certified that Resident #12 was admitted under the care and services of Hospice for end of life care. Review of the Significant Change Minimum Data Set (MDS) dated 11/29/18 specified Resident #12's cognition was severely impaired. Review of Section J1400 (Prognosis- Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?) was coded as Resident #12 not having less than 6 months to live. On 2/26/2019 at 3:18 PM an interview was completed with the MDS Coordinator. The MDS Coordinator stated Section J1400 (Prognosis- Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?) was coded No in error for Resident #12. The MDS Coordinator indicated that J1400 should have been coded Yes. The MDS Coordinator stated the coding error was an oversight and the MDS would be modified. On 2/26/2019 at 4:49 PM an interview was completed with the Administrator. The Administrator stated he expected the MDS to be coded accurately to reflect the resident's status, per the regulations, by the MDS Coordinator. 2. Resident #32 was admitted to the facility on 8/21/18. Diagnoses included, in part, dysphagia and attention to gastrostomy tube. On admission, Resident #32 had a physician (MD) order for NPO (nothing by mouth) and received 100% of his nutrition from an enteral feeding product via a gastrostomy tube. This MD order was discontinued and on 8/29/18 his status	F 641	discharge status. The PASSAR screening portion of Section A, of the MDS for resident #60, dated 1/10/2019, was modified on 2/27/2019, to reflect accurate PASSAR screening information and mental illness information. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Corporate MDS consultant and, or MDS Coordinator, to conduct a Quality Review of current residents MDS for accuracy of Section J1400, Section K0510 and K0710, and Section A1500, A1510 and A2100. Follow up will be based on findings. Audit and any necessary corrections will be completed by 3/22/2019 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Corporate nurse of MDS provided re-education to MDS department on 2/26/2019. MDS Lead nurse to conduct weekly Quality Improvement Monitoring of 5 random MDS assessments completed during the previous 7 days, for accuracy of Section J1400, Section K0510 and K0710, Section A1500, A1510 and A2100. Random audits will be completed and recorded on the MDS QI Log, and submitted to the Administrator weekly for 4 weeks, then monthly for 2 months, then quarterly and prn.	

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F 641	Continued From page 2 was changed to PO (by mouth) with a diet order for a regular diet, solid chopped meats, thin liquids and a nutritional supplement if he ate less than 50% of his meals. Review of Resident #32's August 2018 care plan identified a risk for aspiration and significant weight changes due to change in diet status from NPO to PO. A MD order dated 9/21/18 discontinued the enteral feeding product for Resident #32. Review of a quarterly Minimum Data Set (MDS) assessment dated 10/17/18 assessed Resident #32 as receiving 51% or more nutrition from a tube feeding (Section K). Review of October 2018 meal percentage intake records revealed Resident #32 ate on average 75 - 100% of meals PO. Review of October 2018 Medication Administration Records (MAR) revealed no documentation of administration of an enteral feeding product. On 12/21/18 a MD order was written for Resident #32 to receive a mechanical soft diet with thin liquids. Review of a quarterly MDS assessment dated 1/2/19 assessed Resident #32 as receiving 51% or more nutrition from a tube feeding (Section K). A dietary progress note dated 1/28/19 recorded Resident #32 had a history of requiring enteral feeding to supplement meals, but that he no longer received an enteral feeding product. Review of January 2019 meal percentage intake	F 641	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained : Performance will be reviewed and discussed during Weekly MDS QI Meetings. Meetings will be held by the IDT (consisting of nursing, MDS and social services) every week for four weeks, every month for 2 months, and every quarter during QAPI. Further action(s) will be implemented based on findings. Administrator will be responsible for compliance Corrective action will be completed. 3/28/2019	

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F 641	Continued From page 3	F 641		

records revealed Resident #32 ate on average 75 - 100% of meals PO. Review of January 2019 MAR revealed no documentation of administration of an enteral feeding product.

On 2/25/19 at 4:49 PM, Resident #32 stated he received a mechanical soft diet, he used to receive his nutrition via a tube feeding, but that for the last few months he ate all of his foods by mouth. Resident #32 was observed in his room on 2/26/19 at 9:26 AM eating a mechanical soft breakfast by mouth.

An interview occurred on 2/26/19 at 4:45 PM with the MDS Coordinator and Certified Dietary Manager (CDM) which revealed the CDM and MDS Coordinator completed section K of the MDS. Both reviewed the medical record during the interview and stated a MD order dated 9/21/18 discontinued the use of an enteral feeding product and that there was no record of administration of an enteral feeding product to Resident #32 October 2018 - January 2019. The MDS Coordinator stated "I do not see where he received any tube feeding product in October 2018 - January 2019." The CDM stated that both quarterly MDS should have assessed that Resident #32 received less than 25% of nutrition via a tube feeding.

An interview on 2/27/19 at 2:11 PM with the Director of Nursing (DON) revealed she expected the MDS to accurately assess nutritional status.

An interview with the Administrator occurred on 2/27/19 at 2:28 PM and revealed he expected the MDS to reflect an accurate assessment.

3. Resident #134 was admitted to the facility

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F 641	Continued From page 4	F 641		

11/14/18 and discharged home on 11/27/18.

Diagnoses included, in part, adult failure to thrive, acute on chronic systolic ventricular tachycardia, hypertension, hyperlipidemia, and hypokalemia.

Review of a facility Notice of Transfer/Discharge for Resident #134 dated 11/27/18, documented the discharge location as "Home".

A discharge Minimum Data Set (MDS) assessment dated 11/27/18 assessed Resident #134's discharge status as a planned discharge, to an acute hospital, with return to the facility not anticipated.

An interview on 2/27/19 at 2:11 PM with the director of nursing (DON) revealed the MDS Coordinator who completed the discharge MDS dated 11/27/18 for Resident #134 was no longer an employee of the facility. The DON stated Resident #134 did not discharge on 11/27/18 to the hospital, but discharged home per her plan of care. The DON stated she expected the MDS to accurately assess a residents discharge status and location.

An interview with the Administrator occurred on 2/27/19 at 2:28 PM and revealed the facility identified concerns with MDS accuracy in December 2018 with the MDS Coordinator who completed the 11/27/18 discharge MDS for Rsident #134. He stated that the MDS Coordinator no longer worked for the facility. The Administrator stated this concern was addressed in their quality assurance program and resolved once the nurse was no longer employed. He further stated he expected the MDS to reflect an accurate assessment.

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F 641	Continued From page 5 4. Resident #60 was admitted to the facility on 01/03/19 with diagnoses which included schizophrenia. Review of Resident #60's admission Minimum Data Set (MDS) dated 01/10/19 revealed an assessment of intact cognition. The MDS indicated Resident #60 did not have a mental illness and did not require a Level II Preadmission Screening and Resident Review (PASRR) to ensure appropriate placement in a long-term care facility. Review of Resident #60's admission papers revealed a completed Level II PASRR sent to the facility on the day of admission (01/03/19). Interview with the MDS Coordinator on 02/27/189 at 1:16 PM revealed Resident #60's admission MDS was not accurate regarding presence of mental illness and Level II PASARR. The MDS Coordinator reported the error was an oversight and a corrected MDS would be transmitted. Interview with the Administrator on 02/27/19 at 1;23 PM revealed Resident #60's MDS should be accurate and reflect mental illness and the acquisition of a Level II PASRR.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination	F 644		3/28/19

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F 644	Continued From page 6 includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to resubmit for Level II Preadmission Screening and Resident Review for 1 of 3 residents reviewed for Preadmission Screening and Resident Review (Resident #81). Findings included: Resident #81 was admitted on 1/8/19 with medical diagnoses inclusive of schizophrenia. Review of the admission minimum data set (MDS) dated 1/17/19 revealed a diagnosis of schizophrenia and was moderately cognitively impaired. A review of the hospital discharge summary report dated 1/8/19 revealed an ongoing diagnosis of schizophrenia. A review of the psychiatric evaluation note dated 1/15/19 revealed a diagnosis of schizophrenia. The history of present illness indicated Resident #81 had treatment by psychiatry since 2014 for	F 644	F644. Coordination of PASARR and Assessments. PLAN OF CORRECTION: Address how corrective action will be accomplished for those residents found of have been affected by the deficient practice: Referral placed for Resident # 81 for evaluation of Level II PASRR by SW on 3/19/2019 to NC MUST. Resident #81 is Level I PASSAR due to having primary diagnoses of dementia, which supersedes diagnoses of MI. Address how the facility will identify other residents having the potential to be affected by the same deficient practice SW completed Quality Review of current facility residents for level 2 PASARR - follow up based on findings.– completed on 3/15/2019	

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F 644	Continued From page 7 mental health symptoms. The review of systems noted agitation, distractibility, disorganized/incoherent speech and/or behavior, and paranoid delusions. During an interview on 2/27/19 at 2:34 PM, Nurse #1 reported Resident #81 had an order dated 1/9/19 for consult with psychiatry due to the diagnosis of schizophrenia and observations made by the nursing staff of Resident #81's behavior on admission. Nurse #1 reported Resident #81 was nonverbal, resisted care and appeared to be angry. An interview with the Social Worker (SW) on 2/27/19 at 2:05 PM, the SW stated she was responsible for resubmitting for Level II Preadmission Screening and Resident Review (PASARR). The SW stated she attended meetings when Resident #81's behaviors on admission were discussed, however, she had not referred him for Level II screening. The SW stated her understanding was Level II screening was for residents with a new mental health diagnosis or a significant change that did not apply to Resident #81. An interview with the Administrator on 02/28/19 at 8:50 AM revealed his expectation for a mental health diagnosis for a resident that was not resolved to be referred to the contracted psychiatric provider to help disseminate information regarding dual diagnosis of mental health and dementia. If mental health diagnosis was determined current, then a referral for Level II screening was the expectation.	F 644	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Social Service Director will audit 5 RANDOM initial care plan(s), 5 Significant Change care plans, and 5 Quarterly Care Plans, for PASRR Level 2 documentation: Weekly x 4 weeks, Monthly x 2 months and quarterly for 2 quarters Indicate how the facility plans to monitor its performance to make sure that solutions are sustained : Social Service Director will submit the corresponding PASSAR LEVEL 2 TRACKING LOGS Tracking to the Administrator Weekly x 4 weeks, Monthly x 2 months and quarterly to the QAPI committee for 2 quarters. QAPI committee will evaluate need for further systemic changes necessary to ensure further compliance. Include when correction action will be completed. 3/28/2019	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		3/28/19

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F 804	Continued From page 8 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on an observation of a breakfast tray line, a test tray, 9 of 10 Residents who attended a Resident Council Meeting (Residents #3, #9, #13, #27, #41, #48, #52, #53, and #97), and staff interviews, the facility failed to provide residents with palatable foods regarding preferences for taste and temperature. The findings included: During a Resident Council meeting which occurred on 2/25/19 at 2:00 PM, 9 residents, identified by the facility as alert and oriented, expressed concerns related to food palatability. These Residents stated that for those who ate breakfast in their rooms, breakfast was always cold. Residents also stated that chicken was often overcooked and dry and that vegetables served at lunch and dinner were often overcooked. An observation of the breakfast tray line meal service occurred on 2/27/19 from 7:54 AM until 8:58 AM. During the observation, temperature monitoring conducted by the kitchen supervisor (KS), at the request of the surveyor, revealed the following foods were on the tray line for meal	F 804	F804. Nutritive Value / Appear. Palatable/ Prefer Temp. PLAN OF CORRECTION: 1. Address how corrective action will be accomplished for those residents found of have been affected by the deficient practice: Residents #3, #9, #13, #27, #41, #48, #52, #53, and #97 will receive food according to their preferences for taste and temperature. Alternate menu items will be updated prior to each meal, on white boards located at each common area on each nursing unit and if resident prefers alternate menu item, staff will accommodate preference as indicated. 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 by the alleged deficient practice 3. Address what measures will be put into	

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F 804	Continued From page 9 service with temperatures less than 135 degrees Fahrenheit: · Pureed eggs, 132 degrees Fahrenheit · Scrambled eggs, 130 degrees Fahrenheit A test tray was requested by the surveyor on 2/25/19 at 8:55 AM for a regular diet. The test tray arrived on the 100 unit at 8:58 AM and tested by the KS and surveyor at 9:37 AM. When tested, the KS stated that the scrambled eggs were "luke-warm" and could have used more seasoning, the ham was "luke-warm" and the waffle was cold as evidenced by the butter did not melt, but remained congealed on top of the waffle. During an interview on 2/27/19 at 9:37 AM, the KS and certified dietary manager (CDM), both stated that they were aware of resident complaints of cold foods at the breakfast meal. They stated that residents were invited/encouraged to eat breakfast in the main dining room to help ensure they received a hot breakfast. They stated it was not their practice to monitor temperatures of foods during the tray line to identify foods that did not maintain at least 135 degrees during the tray line meal service. An interview on 2/28/19 at 12:53 PM with the Administrator revealed he was aware of resident complaints regarding food palatability and that the facility was looking at other options to change the dining system.	F 804	place or systemic changes made to ensure that the deficient practice will not recur: Call placed by Administrator to Hobart Service Department to service the Hobart base warmer and Steam table, to ensure they are in working order. Hobart technician identified 2 steam compartments that were in need of service repairs. All repairs will be completed by 3/22/2019. All four temperature control knobs were replaced as well to ensure temperature controls are optimal. Dietary staff will be in-serviced by CDM and, or Dietary Supervisor on the food temperature policy by 3/22/2019. In-service to including proper food temperatures, taking food temperatures of food items on the tray line to ensure food items on the tray line maintain at least 135 degrees during the tray line meal service. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained : Facility will collect resident satisfaction surveys for 5 random residents. Surveys will include information on meal temperature and palatable food(s). Surveys will be conducted and submitted to the Administrator and to QAPI to make sure solutions are sustained. According to the following schedule:	

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F 804	Continued From page 10	F 804	Weekly x 4 weeks Monthly x 3 months Quarterly x 6 months Correction actions will be completed by 3/28/2019	
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 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on an observation of a breakfast tray line and staff interviews, the facility failed to maintain hot foods on the breakfast tray line at least 135 degrees Fahrenheit (F) or above (pasteurized eggs), potentially hazardous cold foods at least 41 degrees F or below (milk) and re-thermalize hot foods (pasteurized eggs) to at least 165	F 812	F812. Food Procurement, Store/Prepare/Serv-Sanitary PLAN OF CORRECTION: 1. Address how corrective action will be accomplished for those residents found of have been affected by the deficient	3/28/19

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F 812	Continued From page 11 degrees F to reduce the potential of bacterial growth and food borne illness. The findings included: An observation of the breakfast tray line meal service occurred on 2/27/19 at 7:54 AM to 8:58 AM. During the observation of the tray line, approximately 78 cartons of milk were observed stored in a clear plastic tray with melting ice. Temperature monitoring conducted by the kitchen supervisor (KS) at 8:08 AM, at the request of the surveyor, revealed the following foods were on the tray line for meal service with temperatures in the danger zone of 135 - 41 degrees F: · Pureed eggs, 132 degrees F; re-thermalized to 145 degrees F · Scrambled eggs, 130 degrees F; re-thermalized to 147 degrees F · Whole milk, 42.6 F and 43.3 degrees F The pureed eggs were re-thermalized to 145 degrees and the scrambled eggs were re-thermalized to 147 degrees F and placed back on the breakfast tray line for meal service. Temperature monitoring was conducted by the KS. During an interview on 2/27/19 at 8:15 AM, dietary aide (DA) #1 stated her typical practice was to place the whole container of milk cartons in the freezer around 6:30 AM for about 30 minutes. Then DA #1 stated she removed the container of milk from the freezer, covered the cartons of milk with ice and placed the container of milk on the tray line which started about 7:20 AM and lasted until about 8:30 AM (1 hour and 10 minutes).	F 812	practice: The food items that were not measuring with correct temperatures were discarded and were not served to residents 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 by the alleged deficient practice • Call placed by Administrator to Hobart Service Department to service the Hobart base warmer and Steam table, to ensure they are in working order. Hobart technician identified 2 steam compartments that were in need of service repairs. All repairs will be completed by 3/22/2019. All four temperature control knobs were replaced as well to ensure temperature control is optimized. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Dietary staff will be in-serviced CDM and, or Dietary Supervisor on the food temperature policy, including proper food temperatures, serving meals and maintaining hot food items on tray line at least 135 degrees, re-thermalized to at least 165 degrees if needed, and cold food items maintained at least 41 degrees.	

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 02/28/2019

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F 812	Continued From page 12 An interview on 2/27/19 at 8:33 AM with the KS and the certified dietary manager (CDM) revealed the eggs were re-thermalized to temperatures less than 165 degrees F and should not be served. During a follow up interview with the KS and CDM on 2/27/19 at 9:37 AM, they stated it was not their practice to monitor temperatures of foods during the tray line to identify hot foods that did not maintain at least 135 degrees or cold foods that did not maintain at least 41 degrees F. An interview on 2/28/19 at 12:53 PM with the Administrator revealed he was looking at other options to change the dining system.	F 812	Milk Temperature Log: Dietary staff will keep milk in the freezer for at least 1 hour (not 30 minutes) before taking it from the freezer and placing it on the line. The dietary staff will perform temperature checks of the milk during the tray line, to ensure safe temperature. The results will be kept on a log. The schedule of removing milk from the freezer and placing it in the ice container for the food line, will be adjusted depending on the ongoing temperature checks. Hot Food Logs: CDM/designee will perform random temperature checks on the eggs on the tray line to ensure temperatures are maintained at minimum 135 degrees. CDM/designee will perform random temperature checks of re-thermalized eggs to ensure temperature reaches at minimum 165 degrees. The schedule of the random logs will be as follows: 5 times a week x 4 weeks 2 times a week x 4 weeks Weekly x 90 days. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained : Above logs will be submitted to the Administrator when completed 5 times a	

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F 812	Continued From page 13	F 812	week x 4 weeks 2 times a week x 4 weeks Weekly x 90 days. Logs will be reported to Quality Assurance and Performance Improvement meetings every quarter to ensure ongoing compliance.	