PRINTED: 07/19/2022 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED	
	345103	B. WING _	B. WING		C 06/09/2022	
	1		STREET ADDRESS, CITY, STATE, ZIP CO 600 FULLWOOD LANE MATTHEWS, NC 28105	ODE	00/00/2022	
SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		E PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		ON SHOULD B HE APPROPRIA		
Initial Comments		E 0	00			
investigation survey through 06/09/22. T compliance with the Emergency Prepared	was conducted on 06/06/22 he facility was found in requirement CFR 483.73, dness. Event ID #JU3B11.	F 0	00			
survey was conducted 06/09/22. Event ID a intakes were investign NC00188176, and N complaint allegations Personal Privacy/Co	ed from 06/06/22 through #JU3B11. The following gated NC00185259, IC00184109. 4 of the 4 s were not substantiated. nfidentiality of Records	F 5	83		7/4/22	
§483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.						
accommodations, metelephone communicand meetings of family this does not require	edical treatment, written and cations, personal care, visits, ily and resident groups, but the facility to provide a					
residents right to per right to privacy in his written, and electron the right to send and mail and other letters materials delivered to including those delivered than a postal service	sonal privacy, including the or her oral (that is, spoken), ic communications, including promptly receive unopened s, packages and other o the facility for the resident, ered through a means other		TITLE		(X6) DATE	
	Initial Comments An unannounced reinvestigation survey through 06/09/22. Tompliance with the Emergency Prepared INITIAL COMMENTS A recertification and survey was conducted 06/09/22. Event ID reintakes were investign NC00188176, and Ncomplaint allegations Personal Privacy/CocFR(s): 483.10(h)(1) §483.10(h) Privacy and the resident has a reconfidentiality of his records. §483.10(h)(l) Personaccommodations, metelephone communication and meetings of fame this does not require private room for each §483.10(h)(2) The faresidents right to per right to privacy in his written, and electron the right to send and mail and other letters materials delivered to including those delivered to the right oper delivered to the right of the residents residents residents residents right to send and mail and other letters materials delivered to including those delivered to the right to send and mail and other letters materials delivered to including those delivered to the right to send and mail and other letters materials delivered to including those delivered to the right to send and mail and other letters materials delivered to including those delivered to the right to send and mail and other letters materials delivered to including those delivered to the right to send and	ROVIDER OR SUPPLIER STON PLACE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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. 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.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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. 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)(Privacy and Confidentiality 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.	ROWIDER OR SUPPLIER TON PLACE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) An unannounced recertification and complaint investigation survey was conducted on 06/06/22 through 06/09/22. The facility was found in complaint envertigation and complaint investigation and complaint investigation and complaint investigation survey was conducted from 06/06/22 through 06/09/22. The facility was found in compliance with the requirement CFR 483-73, Emergency Preparedness. Event ID #JU3B11. 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. 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 a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, 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 these delivered to the facility for the resident, including these delivered through a means other than a postal service.	ROWIDER OR SUPPLIER 345103 ROWIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (RACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 #JUJ8B11. INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/06/22 through 06/09/22. Event ID #JUJ8B11. The following intakes were investigated NC00185259, NC00188176, and NC00184109. 4 of the 4 complaint allegations were not substantiated. 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)(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 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.	A BUILDING COMPLETED C GOMPLETED C GOMPLETED C GOMPLETED C GOMPS/2022 STREET ADDRESS, CITY, STATE, JP CODE SOFT PLACE SUMMARY STATEMENT OF DEPICIENCIES ESCH DEPICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) An unannounced recertification and complaint investigation survey was conducted on 06/06/22 through 06/09/22. Event ID #JU3B11. The following intakes were investigated NCO0185259, NCO0186109. A of the 4 complaint allegations were not substantiated. Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(i) \$483.10(h)(f) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident growth of the resident spit to personal privacy including the right to personal privacy, including the right to personal privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to personal privacy including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for resident, including these delivered through a means other than a postal service.

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.

PRINTED: 07/19/2022 FORM APPROVED OMB NO. 0938-0391

1 '		I DENTIEICATION NUMBED:		ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345103 B. WING			C 06/09/2022		
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	703/2022
				60	0 FULLWOOD LANE		
CARRING	TON PLACE				ATTHEWS, NC 28105		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREFI) TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 583	Continued From pag	ge 1	F 5	583			
	8483 10(h)(3) The re	esident 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						
		nt's medical, social, and					
	administrative record	ds in accordance with State					
	law.						
	This REQUIREMEN by:	T is not met as evidenced					
	·	ons, record review and staff			ACKNOWLEDGEMENT DISCLAIMER	₹	
	interview the facility	failed to respect the residents			Carrington Place acknowledges receip	t of	
	right to privacy and	confidentiality by placing			the Statement of Deficiencies and		
	signage on resident'	s room doors which indicated			proposes this Plan of Correction to the		
	residents' vaccinatio	n status for 8 of 30 resident			extent that the summary of findings is		
		d for confidentiality. (Rooms			factually correct and in order to mainta	in	
	132, 201, 203, 306,	309, 317, 320, 321)			compliance with applicable rules and		
					provisions of quality of care of Residen		
	The findings include	d:			The Plan of Correction is submitted as	a	
	A	- 200 Hall was sandwated an			written allegation of compliance.		
		e 300 Hall was conducted on			Carrington Place's response to this		
		A yellow sign was posted on			Statement of Deficiencies does not	of	
	I .	306, 309, 317, 320 and 321. ntion: This room is occupied			denote agreement with the Statement of Deficiencies nordoes it constitute an	וכ	
		d COVID-19. During a facility			admission that any deficiency is accura	ato	
		dent is on quarantine." The			Further, Carrington Place reserves the		
	signage was visible	•			right to refute any of the deficiencies or		
	oigilage was visible	ioi and public to dec.			this Statement of Deficiencies through	•	
	An observation was	conducted of the 100 Hall			Informal Dispute Resolution, formal		
		22 @11:23 AM. A yellow sign			appeal procedure and/or any other		
	I .	ns 132, 201 and 203. The			administrative or legal proceedings.		
	1	: This room is occupied by a			gui		
	1	OVID-19. During a facility			F583 SS=F: Personal		
	I .	dent is on quarantine." The			Privacy/Confidentiality of Records CFR	R(s):	
	signage was visible			483.10(h)(1)-(3)(i)(ii)	(-)·		

PRINTED: 07/19/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345103	B. WING _				C / 09/2022	
	ROVIDER OR SUPPLIER TON PLACE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 600 FULLWOOD LANE MATTHEWS, NC 28105			00/	03/2022	
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		<	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE
F 583	with the Infection Pre Preventionist stated t was a violation of HIF Portability and Accou Preventionist stated t the signage was not risk to public safety. An interview was con Administrator. The Ac was instructed to plac unvaccinated resider office. The Administrator	ducted on 6/8/22 at 4:18 PM ventionist. The Infection that she felt that the signage PPA (Health Insurance ntability Act). The Infection that she was instructed that a violation because of the ducted on 6/8/22 with the dministrator stated that he ce the signage on the diducted that the ce the signage on the doors by his corporate atter further stated that the there to visually identify those	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 Presider 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 signary 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 door 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 discontinued with revised policy during	nt age on		
F 758 SS=E	l	vchotropic Meds/PRN Use (e)(1)-(5)	F 7	758	rounds. Corrective Action will be completed on July 4, 2022.	,	7/4/22	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		345103	B. WING		C 06/09/2022		
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 600 FULLWOOD LANE MATTHEWS, NC 28105	1 00/03/2022		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION		
F 758	affects brain activities	opic Drugs. hotropic drug is any drug that s associated with mental	F 75	58			
	-	vior. These drugs include, , drugs in the following					
	resident, the facility r §483.45(e)(1) Reside psychotropic drugs a unless the medicatio	ents who have not used re not given these drugs n is necessary to treat a diagnosed and documented					
	drugs receive gradua behavioral intervention	ents who use psychotropic al dose reductions, and ons, unless clinically n effort to discontinue these					
	unless that medication	ursuant to a PRN order on is necessary to treat a ondition that is documented					
	are limited to 14 days §483.45(e)(5), if the prescribing practition	orders for psychotropic drugs s. Except as provided in attending physician or er believes that it is RN order to be extended					

PRINTED: 07/19/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED				
		345103	B. WING _			C 06/09/2022		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 FULLWOOD LANE MATTHEWS, NC 28105	'	00/00/2022		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 758	Continued From particular beyond 14 days, he rationale in the resi indicate the duration §483.45(e)(5) PRN drugs are limited to renewed unless the prescribing practition the appropriateness. This REQUIREMENT by: Based on record replysician interview interview, the facility orders for PRN (as medications were to the reviewed for unneces). The findings includes 1. Resident #62 was	ge 4 e or she should document their dent's medical record and in for the PRN order. orders for anti-psychotic 14 days and cannot be attending physician or oner evaluates the resident for softhat medication. NT is not met as evidenced eviews, staff interviews, s, and Pharmacy Consultant by failed to ensure Physician's needed) psychotropic me limited in duration for 4 of tent #36, #62, #67, #80) essary medications. ed: s admitted to the facility on test that included anxiety	F 7	DEFICIENCY)	y lace that rugs are e renewed or s the hat			
	The quarterly Minin assessment dated #62 was severely coded as having 1 during the assessment coded as received medications during A careplan was last psychotropic medication. The int Physician of any sigmedication, administration	num Data Set (MDS) for 4/19/22 revealed Resident ognately impaired. She was to 3 days of rejection of care tent period. Resident #62 was ring any PRN psychotropic the assessment period. I revised on 6/2/22 for ation use due to anxiety and erventions included to notify de effects related to the ster medications as ordered by hitor Resident's behaviors.		have been affected by the defici practice; The RN manager completed a psychotropic medication audit or resident(s) #36, #62, #67, #80 a immediately corrected items not survey 1. Resident # 62: Physician ordefor 6/2/22 Lorazepam 2miligram (mg)/milliliter (ml) oral concentratevery 4 hours as needed for any charge nurse consulted with the resident sphysician / prescribing provider. The medication was	ent a QA prn n nd ed during er dated ate 0.25ml kiety. The			

PRINTED: 07/19/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345103	B. WING			C 6/09/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	Ordoredee
				600 FULLWOOD LANE		
CARRING	TON PLACE			MATTHEWS, NC 28105		
(X4) ID	1	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE
F 758	Continued From page	ge 5	F 75	8		
	Continuou i rom pu	900	173	discontinued on 6/11/2022.		
	A Physician order d	ated for 6/2/22 indicated		discontinued on 0/11/2022.		
	-	am (mg)/milliliter (ml) oral		2. Resident #67: Physician ord	ler dated for	
		every 4 hours as needed for		6/1/22 indicated Lorazepam 2r		
		d without a stop date.		concentrate 0.5mg every 4 hou		
	,	•		needed for agitation or restless		
	2. Resident #67 wa	as admitted to the facility on		charge nurse consulted with th		
	1/6/20 with diagnos	es that included Alzheimer's		resident⊡s physician / prescrib	oing	
	disease, depression	n, and anxiety disorder.		provider. This medication was discontinued on 6/15/2022		
	The quarterly MDS	assessment dated for 4/29/22				
	indicated Resident #67 was severely cognitively impaired. She was not coded as having any			3. Resident #80: Physician ord		
				5/27/22 for Lorazepam (medic		
		ns or having received any		anxiety) 0.5 milligram (mg) tab		
		nedications during the		hours as needed for severe ag		
	assessment period.			charge nurse consulted with the resident⊡s physician / prescrib		
		revised on 6/1/22 for the use		provider. This medication was		
	The careplan includ	c medications due to anxiety. led interventions to provide		discontinued on 6/9/2022.		
		ered, monitor Resident's		4. Resident #36: Physician's o		
	-	nysician of any abnormal		4/29/22 for Lorazepam 2 millig		
	changes in behavio	rs.		(mg)/per 1 milliliter (ml)oral cor		
	A Physician's order	dated for 6/1/22 indicated		0.5 mg by mouth (PO) or subli every 6 hours as needed. The		
		dated for 6/1/22 indicated oral concentrate 0.5mg every		nurse consulted with the reside	-	
		for agitation or restlessness		physician / prescribing provide		
	was ordered withou	<u> </u>		medication was discontinued of		
		ew was completed on 06/09/22		Address how the facility will ide	-	
		ysician #1. He indicated PRN		residents having the potential		
	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			affected by the same deficient	•	
				A facility wide physician orde		
				conducted by the Nurse Mana		
				Team on 6/9/2022. All resident		
				orders for psychotropic medica		
	overlooked adding a stop date to the medication order, the pharmacy alerted him to do so when			reviewed to ensure the physici limits the duration to 14 days.	an order	
		Resident's medications.		Residents do not receive	DDN	

		1 / 11 201221110		(X3) DATE SURVEY COMPLETED		
	345103	B. WING		C 06/09/2022		
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 600 FULLWOOD LANE MATTHEWS, NC 28105	1 00/00/2022		
PREFIX (EACH DEFICIENCY MUST E	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI)		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
A telephone interview was or at 1:57 PM with the Pharmar indicated PRN psychotropic an initial 14 day stop date. T Consultant continued to stat reevaluated the Resident for medication and documented extending the medication. An interview was completed with the Director of Nursing it was her expectation that g psychotropic medications has included in the order. Findings included: 3. Resident #80 was admitted 1/29/19 with diagnoses whice is, dementia, and anxiety. Record review of the Minimu Quarterly Assessment dated Resident #80 had severe con Resident #80 was not coded anti-anxiety medication during period. A physician order dated 5/27 (medication for anxiety) 0.5 severy 4 hours as needed for no stop date. During an interview on 6/08/Nurse Manager (NM) reveal Resident #80's PRN Loraze a stop date but stated the Nu did not have a stop date writ NM was unable to state why	cy Consultant. She medications required the Pharmacy ethe Physician then continued use of the Ithe rationale for on 6/9/22 at 2:46 PM (DON). She indicated oing forward all PRN ave stop dates ed to the facility on the included Alzheimer arm Data Set (MDS) in 5/6/22 revealed gnitive impairment. If for as needed (PRN) ing the assessment are severe agitation with each of the severe agitation with the control of	F 75	psychotropic drugs unless med is necessary to treat a diagnosed specondition that is documented in the record 2. PRN orders for psychotropic dare limited to 14 days. If order need extended, physician should docume their rationale in the medical recordindicate the duration 3. PRN orders for antipsychotic dare limited to 14 days. Orders cannot renewed unless physician evaluate resident for continued appropriatent med 4. Nurses receiving new orders PRN antipsychotic medication musensure the above is completed. III. Address what measures will be place or systemic changes made to ensure that the deficient practice with the deficient practice with the place of systemic days and the ensure that the deficient practice with the DNS on 6/10/2022 regarding following information: 1. Residents do not receive PRI psychotropic drugs unless med is necessary to treat a diagnosed specondition that is documented in the record 2. PRN orders for psychotropic dare limited to 14 days. If order need extended, physician should documented in the medical record indicate the duration 3. PRN orders for antipsychotic dare limited to 14 days. Orders cannot renewed unless physician evaluate	rugs ds to be ent d and drugs do t be es the ess of for t put into dill not discation g the N recific clinical rugs ds to be ent d and drugs ds to be ent d and drugs do to be ent d and drugs do to be ent d and drugs do to be		

PRINTED: 07/19/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		345103	B. WING _			06/	/09/2022	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CARRING	TON PLACE			60	00 FULLWOOD LANE			
CARRING	TON FLACE			M	IATTHEWS, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 758	Continued From page	e 7	F 7	'58				
	s PRN Lorazepam. During an interview of NP revealed she norm	on 6/09/22 at 10:21 am the mally wrote for a 14-day stop			resident for continued appropriateness med 4. Nurse(s) receiving new orders for PRN antipsychotic medication will ensu prescribed orders are limited to 14 day	ıre		
	she wrote the new or written previously. T the nurse to notify he	it on this order. She stated der on 5/27/22 as it was he NP stated she expected or if the stop date was not en order for Resident #80' s			PRN Psychoactive QA audits have been developed. The RN Nurse Managers we conduct daily reviews of all new medication orders, to identify new PRN psychotropic medication orders. When the RN Nurse Manager observes new	rill I		
	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.				psychotropic medication orders, the R Nurse Manager will audit the order to ensure a 14-day stop date is included i the physician order, and the order is correctly entered into the EHR by the receiving nurse(s). All incidences of no compliance with the PRN stop date will	N n n l be		
	revealed he expected Lorazepam order to he the facility had check expected the PRN Lo	e expected Resident #80' s PRN order to have a stop date. He stated had checks and balances in place and he PRN Lorazepam order to be ordered a stop date was in place. Included on the QA log, the Find Manager will document the form Date, Resident Name, Medical Ordered, Corrective Action / 0 Date, and Signature. The PR		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	ne			
	1/18/19 with diagnose	admitted to the facility on es that included chronic y disease, anxiety disorder, e disorder.			weekly by the DNS to ensure corrective actions have been completed. IV. Indicate how the facility plans to monitor its performance to make sure to			
	(MDS) assessment d Resident #36 had mo impairment. Resident	erly Minimum Data Set lated 3/17/22 revealed that oderate cognitive t #36 was coded as receiving ation for seven days of the			solutions are sustained. The Director of Nursing will monitor P Psychoactive QA logs weekly for 12 weeks and monthly for 6 months. The DNS will present the results of this aud the Quality Assurance Performance Improvement committee for the next 3	RN		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345103	B. WING _				C 09/2022
	ROVIDER OR SUPPLIER			60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FULLWOOD LANE IATTHEWS, NC 28105	<u> </u>	00/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	2 milligrams (mg)/per concentrate 0.5 mg b (SL) every 6 hours as During an interview w 6/9/22 at 11:10 AM, s normally wrote for a 1 not write it on this ord expected the nurse to was not included. An interview was con Nursing (DON) on 6/5 stated that she expected	ated 4/29/22 for Lorazepam 1 milliliter (ml)oral y mouth (PO) or sublingual s needed without a stop date. with the Nurse Practitioner on the revealed that she 4 day-day stop date but did ter. The NP stated she o notify her if the stop date ducted with the Director of 8/22 at 3:01 PM. The DON sted all PRN psychotropic a stop date included in the store/Prepare/Serve-Sanitary 2) ty requirements. The food from sources the satisfactory by federal, ties. The food items obtained directly subject to applicable State sulations. The stop of the stop date subject to applicable state sulations. The food from sources the stop of the stop date directly subject to applicable state sulations. The food from sources the stop of the stop date directly subject to applicable state sulations. The food from sources the fo		758	consecutive QAPI meetings. The QAP committee can make changes to ensur 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		7/4/22

PRINTED: 07/19/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345103	B. WING		C 06/09/2022	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/09/2022	
			600 FULLWOOD LANE		
CARRINGTON PLACE			MATTHEWS, NC 28105		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
by: Based on observate facility failed to material and in a sanitary material contamination by fabuildup from 1 of 1 hand sinks, maintate of food debris and vents free of dust. During the initial kith AM the ice cream food 2 inch buildup of ice baking sheets were use with a build up inch under the rim. During an observate hand sink located in was observed. The brown stains and the was dirty. The ice of have a 2 inch buildup of dust. During a kitchen of AM with the dietary observed to be in the line and interview on the manager stated should in an interview on the manager stated should in an interview on the manager stated should in a sanitary manager stated should in an interview on the manager stated should in the sanitary manager stated should in the sanitary manager stated should interview on the manag	service safety. NT is not met as evidenced tion and staff interviews the intain kitchen equipment clean, nanner to prevent cross ailing to remove excessive ice ice cream freezer, clean 1 of 2 in 12 of 12 baking sheets free maintain 2 of 2 ice machine The findings included: tchen tour on 6/7/22 at 11:29 freezer was observed to have a e on the interior. 12 of 12 e observed stacked ready for of dark dried food debris ½	F 812	F812 SS=E: Food Procurement, Store/Prepare/Serve- Sanitary CFR(s): 483.60(i)(1)(2) 1. Failing to remove excessive ice build 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 relat to food safety requirements. Address how corrective action will be accomplished for those residents found have been affected by the deficient practice; The ice cream freezer was dethawer on 6/10/2022 Address how the facility will identify oth 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 be the Food Service Director on 6/10 on the requirements to ensure ice cream freezer is free from ice buildup. Dietary superventilly perform visual checks on ice cream freezer and record findings on the Diet QA Monitoring Log, 5xper week for 4	ted d to d ner ; o ot vy he zer risor	

PRINTED: 07/19/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		0.45400		D. WING		С	
		345103	B. WING _	WING		06/	09/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARRING	TON PLACE			6	00 FULLWOOD LANE		
0,	10.11. 27.02			N	IATTHEWS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	÷ 10	F	312	weeks than 3xper week for 2 months. The Dietary Supervisor will present the result 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 monitority plans in compliance Indicate how the facility plans to monitority plans are sustained; Dietary supervisor will perform visual checks on ice cream freezer and recording findings on the Dietary QA Monitoring Letary Supervisor was 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 planse correction. Include dates when corrective action was becompleted 7/4/2022 2. Clean 1 of 2 hand sinks Address how corrective action will be accomplished for those residents found have been affected by the deficient practice; Hand sink and surrounding area was thoroughly cleaned. Address how the facility will identify oth	or al d .og, ek rill ne ce	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345103	B. WING _			C 06/09/2022
	ROVIDER OR SUPPLIER TON PLACE			STREET ADDRESS, CITY, STATE, Z 600 FULLWOOD LANE MATTHEWS, NC 28105	I ZIP CODE	00/03/2022
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN ((EACH CORRECTIVE	
F 812	Continued From page	e 11	F&	residents having the poraffected by the same de All residents have a affected by this Address what measures place or systemic change ensure that the deficien recur; Kitchen staff receive the Food Service Direct requirements to clean the surrounding surfaces be each shift. Dietary supe hand sink area for clear document findings on the monitoring log Indicate how the facility its performance to make solutions are sustained; Monitoring of the corensure the deficient pra reoccur. The Dietary Sucomplete visual inspect daily and complete Diet log 5xper week for 4 wwweek for 2 months. The Supervisor will present audit to the Quality Assi Performance Improvem monthly x3. The QAPI of make changes to ensur remains in compliance. Include dates when combe completed 7/4/2022 The Administrator is resident.	eficient practice; potential to be swill be put into ges made to at practice will not tor on 6/10 on the hand sinks arefore the end of ervisor will monitor and present to monitor es ure that; and prected action to actice will not upervisor will ion of hand sinks tary QA monitoring eeks than 3xper end potential potential present committee committee committee committee committee can be the facility	e and or a sang

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILT		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		345103	B. WING _			C 06/09/2022		
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 600 FULLWOOD LANE MATTHEWS, NC 28105				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)			
F 812	Continued From pag	e 12	F 8	implementation of correction. 3. Maintain 12 of 1 food debris Address how correaccomplished for thave been affected practice; Dietary departn 12 baking sheets. Address how the firesidents having that feeted by the sar All residents has affected. Address what mean place or systemic densure that the derecur; Kitchen staff rethe Food Service I on the requirement to be clean and fredebris buildup. The will complete visual sheets daily and reduced to mainly performance to mainly are sustained; and	acility will identify othe potential to be me deficient practice we the potential of be assures will be put into changes made to ficient practice will not ceived re-education. Director on 6/10/2022 ts of dietary equipment of the Dietary Supervisor al inspection of baking each of the corrected action to the corrected action to the practice will not ary Supervisor will spection of baking	of I to If er ; eing ot by ent r g		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		OMPLETED
		345103	B. WING			C 06/09/2022
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 600 FULLWOOD LANE MATTHEWS, NC 28105	•	06/03/2022
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 812	Continued From page	ge 13	F8	Dietary QA monitoring log 5xperal 4 weeks than 3xper week for 2. The Dietary Supervisor will present the facility remains in compliant linclude dates when corrective a be completed 7/4/2022 The Administrator is responsible implementation of the acceptate correction. 4. Ice machine vents must be facility accomplished for those resident have been affected by the deficipractice; Vents were cleaned by main staff on 6/9/2022 Address how the facility will idear residents having the potential to affected by the same deficient affected. Address what measures will be place or systemic changes made ensure that the deficient practice; Kitchen staff received re-ed the Food Service Director on 6 on the requirements to ensure machine vents are regularly instance.	months. esent the ity vement API to ensure ice action will le for ole plan of iree of dust will be nts found to cient intenance entify other to be practice; itial of being e put into de to ce will not lucation by /10/2022 ice	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345103	B. WING_				09/2022
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 600 FULLWOOD LANE MATTHEWS, NC 28105			09/2022
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION			(X5) COMPLETION DATE
F 814 SS=E	(,,		F8		be free of dust. Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Dietary Supervisor will complete visual inspectice machine air filters weekly and recorfindings on Dietary QA monitoring log weekly for 12 weeks. Indicate how the facility plans to monitority plans to monitority 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 filters weekly and record findings on Dietary QA monitoring log weekly for 13 weeks. The Dietary Supervisor will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. TI QAPI committee can make changes to ensure the facility remains in compliance Include dates when corrective action we be completed 7/4/2022 The Administrator is responsible for implementation of the acceptable plan correction.	on d or air 2 ne ce	7/4/22
		is not met as evidenced					

PRINTED: 07/19/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
			7. BOILDING			С	
		345103	B. WING _	06/09		6/09/2022	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
CARRING	TON PLACE			600 FULLWOOD LANE			
CARRING	ION PLACE			MATTHEWS, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETI DATE			
F 814	Continued From page	e 15	F 8	14			
	· -	on and staff interviews the		F814: Dispose Garbage an	d Refuse		
		ain 1 of 1 dumpster in good		Properly CFR(s): 483.60(i)(4			
	· ·	ned waste and was free of			• /		
		ent in 2 of 2 observations of		483.60(i)(4)- Dispose of gar	bage and		
	the dumpster. The fi	ndings included:		refuse properly.	J		
	·			Address how corrective acti	on will be		
	An observation on 6/	07/22 at 11:11 AM of the		accomplished for those residual	dents found to		
	•	led a leak. The front-end		have been affected by the d	eficient		
		ipster was observed with wet		practice;			
	_	e underneath the frame. Liquid was Facility administration contacted waved leaking out, with a build up of black management company on 6/8/2022 at					
		me and on the ground. 3 of		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			
		rs were observed to have Idup of black sludge on the					
	dumpster and 1 foot						
	dumpsion and 1 look	wide on the ground.					
	A second observation	n of the dumpster on 6/8/22					
		e with the Administrator. The		affected.			
	front-end underside of	of the dumpster was		Address what measures will be put into			
		udge underneath the frame.		place or systemic changes made to			
	5 to 6 flies were obse	erved in the area. Liquid was		ensure that the deficient practice will n			
		out, with a buildup of black		recur; EVS management team received education on requirement to maintain			
	_	ne and on the ground. 3 of					
		rs were observed to have					
	paper debris and buildup of black sludge on the dumpster and 1 foot wide on the ground. dumpster and 1 foot wide on the ground. dumpster in good condition and free leaks. EVS supervisor will perform vertically an extra		· _ · _ · _ · _ · · · · · · · · ·				
	In an interview on 6/8	0/22 at 4:25 DM tha		checks on dumpster daily a			
		the dumpster had recently		visual inspection checks on Compactor QA monitoring to			
		nould not leak. He indicated		EVS will contact trash comp			
	he would call the dun	·					
	immediately.	···		leaking.			
			Indicate how the facility plan				
	_	nager indicated the dumpster		its performance to make sur	e that		
	should not leak and s			solutions are sustained			
	maintenance man im	mediately.		Monitoring of the correct			
				ensure the deficient practice reoccur. The EVS Director v			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTIO G	(X3) DATE SURVEY COMPLETED		
		345103	B. WING			C 06/09/2022	
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 600 FULLWOOD LANE MATTHEWS, NC 28105			
(X4) ID PREFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORREC' REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREN		ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRIA DEFICIENCY)				
F 814	Continued From pag	e 16	F	results of the Monitoring week x 4 who QAPI control basis for 6 can make remains in linclude data be completed 7/4/2022	nistrator is responsible for ation of the acceptable plan	nd ree	