STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966948	02/01/2018
NAME OF PROVIDER OR SUPPLIER **CARINGTON MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **3215 EAST JAMES LEE BLVD** **CRESTVIEW, FL 32539**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Limited Nursing Services monitoring visit was conducted on , 2018 at the Carington Manor assisted living facility, licensure number 11068. There were deficiencies found at the time of the survey.

N276 - LNS - Nursing Services - 58A-5.031(1) FAC

Based on record reviews and staff interviews, the facility failed to ensure residents who were receiving nursing services were placed under the facility's limited nursing services for 2 of 4 sampled residents (#3 and #4).

The findings were:

On an interview was conducted with the facility administrator beginning at approximately 9:35AM. The administrator stated they only had 2 residents receiving limited nursing services. Each were receiving physician ordered toe nail trimming by the registered nurse.

An interview was conducted with the facility registered nurse, staff A, on at approximately 10:00AM. The nurse was asked if any residents had wounds of any type. This staff revealed resident #3 had of her lower legs. She stated the facility nursing staff had been providing care and dressing changes to the areas for the past couple of weeks. The nurse stated resident #3 was also being seen by the hospice nurse who also provided care and dressing changes when she visited. Staff A stated she only worked Thursday and Friday of each week and she changed the dressing last Thursday.

During a continued interview with Staff A, she revealed the facility nursing staff performed application of medications and a dressing change on resident #4 as needed. This nurse stated the resident suffered with and currently had an open area of her right . The nurse stated the facility nurses performed the care and the dressing changes everyday as needed and when the hospice nurse had not performed it.

An interview was conducted on at approximately 11:03AM with the hospice nurse for resident #3. The hospice nurse stated that the resident developed 2 within the past 2 weeks. She stated the facility staff were cleaning the area and applying a dry dressing to the area as needed . She also stated she examined the resident today and the were considered healed as of today.

Record review for resident #4 revealed a physician order dated for 500mg to crush

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and sprinkle one tablet on to on right and apply dressing as needed for odor. Record review of the hospice nursing notes dated revealed the hospice registered nurse and the facility nursing staff continued to provide care and dressing changes to resident #4's right as ordered and continued to sprinkle 500 milligram (mg) on to the bed for mal odor. Record review revealed the original order was dated for 375mg to be crushed and sprinkled on to the bed and dressing applied as needed for mal odor. Record review of the facility's 2018 medication administration record revealed documentation of the care being done on , , , , and by the facility nursing staff.

An interview with the administrator on at 11:09 AM confirmed the dressing changes were done everyday as needed by the facility nursing staff. She confirmed neither resident was placed on limited nursing services as required.

Class III

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on record review and staff interview, the facility failed to ensure staff maintained a current Level II background screen for 1 of 3 staff (B).

The findings were:

Review of the personnel record for staff B, registered nurse, revealed a Level II background screen with an eligible date of . Record review and interview with the administrator at 11:36AM on confirmed that staff B's Level II background screening was overdue and should have been repeated in 2017. The administrator reviewed the background screening web site and found "a new screening was required" for the staff. She stated they would get a new screening done immediately.

Unclassified