STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255301	A. BUILDING _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON, LLC D/B/A THE CARRINGTON	307 REED RD STARKVILLE, MS 39759

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification along with complaints, MS #15923 and MS #15979, from 11/12/19 to 11/14/19. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate MS #15923 for abuse and neglect and did not substantiate MS #15979 related to accidents with injury. There were no citations related to the complaints, however, the SA cited F656 during the survey.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		12/13/19

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to develop a comprehensive care plan for Resident #2 and #36 for Foley Catheter and Resident #26 for Urinary Tract Infection (UTI); three (3) of 19 care plans reviewed. Findings Include: Review of the facility's policy, Care Plans, last updated 3/28/18, revealed: Each resident will have a person-centered plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. Resident #26 Review of Resident #26's medical record revealed the Resident was admitted to the hospital on 9/17/19, with a Urinary Tract Infection	F 656	I. What correction action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #26 was assessed on November 14, 2019 by the Director of Nursing (DON). No adverse outcomes were identified to Resident #26 related to the alleged deficient practice of failure to develop a care plan for a new diagnosis of Urinary Tract Infection (UTI) upon the resident's return from the hospital. Resident #36 was assessed on November 13, 2019 by the DON. No adverse outcomes were identified to Resident #36 related to the alleged deficient practice of failure to develop a care plan for a foley catheter. Resident #2 was assessed on November	

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F 656	Continued From page 2 (UTI) and returned to the facility on 9/24/19. There was no evidence to indicate a care plan was developed upon her return from the hospital for the new diagnosis of UTI. On 11/14/19 at 11:07 AM an interview with the Director of Nursing (DON) revealed she was not here during that time and the MDS Nurse was new and was in orientation. On 11/14/19 at 11:08 AM, an interview with the Administrator revealed the DON at the time was responsible for developing new care plans. The Administrator stated the facility has always brought new orders to the stand up meeting daily, but will now start updating and developing care plans during the stand up meeting. The Administrator stated development of care plans and updating care plans has been a problem, and will be monitored during stand up meetings. Resident #36 A review of Resident #36's medical record revealed she was admitted to the facility on 10/16/19, with a Foley catheter. Review of Resident #36's current care plan revealed the facility failed to develop a care plan related to the Foley catheter. On 11/13/19 at 2:40 PM, an interview with the DON revealed the resident was admitted on 10/16/19, with the Foley catheter due to Urinary Retention and staff failed to care plan the Foley catheter. During an interview on 11/13/19 at 2:47 PM, the Minimum Data Set (MDS) Coordinator stated upon admission, she assesses the resident and care plans any problem areas. The MDS	F 656	13, 2019 by the DON. No adverse outcomes were identified to Resident #2 related to the alleged deficient practice of failure to develop a care plan to monitor the care of a foley catheter. II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. Residents in the facility who have a foley catheter in place as identified by the electronic medical record have the potential to be affected by this deficient practice. Residents in the facility who have a new diagnosis of an UTI as identified by the electronic medical record have the potential to be affected by this deficient practice. III. What Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Facility Nurses were in-serviced on November 25, 2019 by the Nursing Home Administrator regarding the development of comprehensive person-centered care plans to include foley catheters and the interventions on the care plan for the monitoring of care of the foley catheters. Facility Nurses were in-serviced on November 25, 2019 by the Nursing Home Administrator regarding the development of comprehensive person-centered care plans to include any new UTI diagnosis.	

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F 656	Continued From page 3 Coordinator stated she failed to recognize the Resident had a Foley catheter and did not care plan the catheter. K. Raines Resident #2 On 11/13/19 at 2:00 PM, observation revealed Resident #2 had a Foley catheter. Record reveal revealed Resident #2 had a Foley Catheter inserted on 02/13/19, and the resident had a physician's order dated 02/13/19, to change the Foley catheter and irrigate with 50 milliliters (ml) of normal saline as needed. Review of Resident #2's current care plan revealed the resident did not have a care plan to monitor the care of the Foley catheter. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD), dated 08/05/19, revealed the resident had a catheter, but the facility failed to develop a care plan. An interview with the Director of Nursing (DON) on 11/13/19 at 2:20 PM, confirmed the resident did not have a care plan for the Foley catheter and stated, "I guess it just got over looked and no one developed a care plan." During an interview with the MDS Nurse on 11/13/19 at 2:40 PM, she stated she had began the MDS position in September. She reviewed the record and stated she did not find a care plan for the Foley catheter for Resident #2 and stated, "We will have to add a care plan for the catheter right away."	F 656	Staff Development nurse will audit care plans for foley catheters including interventions for care of the foley catheter and care plans for new diagnosis of an UTI for five residents (if the facility has five residents with foley catheters noted in place and new diagnosis of an UTI) weekly for four weeks then monthly for two months beginning November 25, 2019. IV. Monitoring the corrective actions through the Quality Assurance Program to ensure that the alleged deficient practice does not recur. A complete facility audit of resident care plans regarding the use of a foley catheter to include catheter care and the care of a new diagnosis of an UTI was completed by the Minimal Data Set Coordinator on November 25, 2019. The Director of Nursing will audit for the development of a foley catheter care plan including the monitoring of care of the catheter and for the development of a care plan for a diagnosis of a new UTI for five residents (if there are five residents noted in the facility with use of a foley catheter or a new diagnosis of UTI) weekly for four weeks then monthly for two months beginning November 27, 2019. Findings of the audits will be presented monthly to the Quality Assurance Committee for further review and recommendations to ensure ongoing compliance beginning December, 2019.	

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F 656	Continued From page 4 The DON and the MDS Nurse both confirmed, during their respective interviews, that they have weekly high risk meetings and discuss residents with catheters, but they did not check to verify the resident had a care plan for the Foley catheter during those meetings. They confirmed that the only time they evaluated for a care plan is during the quarterly or annual MDS assessments.	F 656		

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	255301	A. BUILDING **01 - THE CARRINGTON** B. WING _____	**11/21/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect all the generator required components as directed by NFPA 110 section 5.6.6 and NFPA 99 section 6.4.1.1.17. This deficiency had the potential to affect all residents in the facility at the time of survey. Findings include: On November 21, 2019 at 10:50 AM, observation revealed the annunciator panel was incapable and inoperable of sending signals and warning to the generator operating in the facility. The annunciator panel was in a continuous supervised location of the facility.	K 916	I. What correction action will be accomplished to protect all the generator required components found to have been affected by the alleged deficient practice? On November 21, 2019, the facility notified TAYLOR Power Systems of the failure of the remote annunciator to send signals and warning to the generator operating in the facility. The remote annunciator panel replaced 11/27/2019 by TAYLOR Power Systems. II. Steps taken to identify other residents having the potential to be affected by the	12/13/19

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K 916	Continued From page 1	K 916	same alleged deficient practice. Every resident in the facility has the potential to be affected by this alleged deficiency. III. What Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Maintenance Director in-serviced by Mark Jett from Taylor Power Systems on November 27, 2019 of the procedure in order to test the remote annunciator for proper functioning. Maintenance Director will perform and document weekly test for three months to ensure the annunciator is capable and operable of sending signals and warning to the generator operating in the facility starting 11/27/2019. IV. Monitoring the corrective actions through the Quality Assurance Program to ensure that the alleged deficient practice does not recur. Nursing Home Administrator will audit test findings for four weeks, then monthly for two months beginning December 6, 2019. Test findings will be presented monthly to the Quality Assurance Committee for three months for further review and recommendations to ensure ongoing compliance beginning December, 2019. Quality Assurance Committee to determine need for further review thereafter.	

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E 000	Initial Comments ********** Survey conducted on 11/21/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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