

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 195483	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2020
NAME OF PROVIDER OF SUPPLIER CARRINGTON PLACE OF BATON ROUGE		STREET ADDRESS, CITY, STATE, ZIP 8225 SUMMA AVENUE BATON ROUGE, LA 70809	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0609 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure a reportable incident was reported to the State Agency for a fire which occurred in the facility. There were 97 residents who resided in the facility. Findings: A review of state form titled Guidance for Mandated Reporting for Allegations of Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Reportable Incidents dated 09/10/2018 and revised on 10/04/2018 revealed the following, in part: III. Emergency Situations requiring report, as determined by the NF, to LDH/HSS via electronic database(s), implementation of corrective actions(s), and/or referrals, as applicable to the appropriate authorities/agencies: A NF must report to the appropriate agency any emergency situation that poses a threat to residents, staff, public health and safety. This includes situations resulting in death or serious harm or injury of a resident for which the police or the local fire authority must be notified or summoned in order to maintain safety. Emergency situations may include but are not limited to: Fire A review of the Health Standards Incident Report provided by the facility revealed the following, in part: Entered: 07/17/2020 Occurred: 07/06/2020 Discovered: 07/06/2020 Incident Description: On 07/06/2020 at approximately 8:45 a.m., the fire alarm began to sound. Staff immediately proceeded to the fire panel and announced the location of the fire. Staff proceeded to the location of the fire which was Room a. Staff observed smoke coming from the Residents closet and the sprinkler had also been activated. No Residents were in the room at this time. Fire Department arrived to the facility and assessed the situation. On 07/20/2020 at 11:40 a.m., an interview was conducted with SIADM. She stated there was a fire in the closet by the second bed in room a on 07/06/2020. She stated the sprinkler system in room a, and the fire alarm were automatically activated. She said the fire department arrived shortly after the alarm sounded. She was asked if a SIMS report had been submitted to the state agency regarding the fire. SIADM stated a SIMS report was not submitted until the state contacted her last week and told her to submit one. SIADM further stated she did not know she was required to submit a SIMS report for a fire.		
F 0610 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure a thorough investigation was conducted for a fire which occurred in the facility. There were 93 residents who resided in the facility. Findings: A review of the Health Standards Incident Report provided by the facility revealed the following, in part: Entered: 07/17/2020 Occurred: 07/06/2020 Discovered: 07/06/2020 Incident Description: On 07/06/2020 at approximately 8:45 a.m., the fire alarm began to sound. Staff immediately proceeded to the fire panel and announced the location of the fire. Staff proceeded to the location of the fire which was Room a. Staff observed smoke coming from the Residents closet and the sprinkler had also been activated. No Residents were in the room at this time. Fire Department arrived to the facility and assessed the situation. A review of the Fire Investigation Report filed by local fire department revealed the following, in part: Report date: 07/08/2020 Fire Department Response On July 6, 2020 at 0900 hours ---- (Local Fire Department) dispatched to a reported fire alarm. Upon arrival, fire suppression personnel discovered that the sprinkler in the closet of room a was flowing due to clothes being set on fire. Conclusions Based on the scene examination and the fire patterns, evidence collected and analyzed, interviews and artifacts identified, observed, and evaluated during this investigation, it is my opinion that the fire was caused by the direct and intentional actions of an unknown suspect. It is my opinion that this fire was caused by intentionally igniting the t-shirt in the closet of Room a. The t-shirt was ignited with an open flame from a device such as a lighter or match. On 07/20/2020 at 11:40 a.m., an interview was conducted with SIADM. She stated there was a fire in the closet by the second bed in room a, on 07/06/2020. She stated the sprinkler system in room a and the fire alarm were automatically activated. She said the fire department arrived shortly after the alarm sounded. She stated no residents were in the room at the time of the fire and no one in the facility was injured. She stated the report from the fire department determined that the fire had probably been started with a lighter or match. She stated she has not been able to determine what or who started the fire. SIADM was asked if all smokers in the facility had been reevaluated for safe smoking as part of the investigation. She stated one resident who smokes was reevaluated the day after the fire. SIADM confirmed that all the residents in the facility who smoke had not been reevaluated for safe smoking.		
F 0623 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to notify a resident and the resident's representative(s) of the transfer and the reasons for the move in writing and in a language and manner they understand at least 30 days before the transfer for 10 (#1, #6, #7, #11, #12, #13, #14, #17, #20, #33) of 34 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34) Residents reviewed. Findings: An interview was held with SIADM on 07/20/2020 at 11:40 a.m. She confirmed they were transferring residents out because they were renovating a hall. She also confirmed they had a fire in their facility on 07/06/2020. A review of the facility's Admission, Transfer and Discharge log for July 2020 revealed the following: Resident #7, Resident #11, Resident #12, Resident #13, Resident #14 and Resident #33 were transferred to a sister facility on 07/16/2020. Resident #6, Resident #17 and Resident #20 were transferred to a sister facility on 07/17/2020. Resident #1 was documented as being transferred to a local hospital on [DATE]. Resident #1 Review of the face sheet for Resident #1 revealed the resident was admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]. Further review of the face sheet revealed the resident was discharged. Review of the most recent MDS for Resident #1 with an ARD of 05/12/2020 revealed the resident had a BIMS of 14 which indicated the resident was cognitively intact. On 07/21/2020 at 9:41 a.m., an interview was conducted with Resident #1. He stated he just recently moved to the sister facility. He stated he was told he had to be moved because of renovations. He stated there was nothing wrong with his room at the facility. He stated they gave him notice 2 days prior to his transfer. He stated there was no paperwork. He stated he really did not have a choice. He stated he was told he was moving and it was temporary. He stated if given the choice, he did not want to move. Resident #6 Review of the face sheet for Resident #6 revealed the resident was admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]. The resident was discharged from the facility on 07/17/2020. Review of a note documented by S3SSD revealed on 07/17/2020, Resident #6 was informed of the transfer to the sister facility due to renovation. Resident and family was ok with the move, Resident was informed once renovations were over, they would return back to facility. On 07/21/2020 at 9:50		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

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 0623 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>(continued... from page 1)</p> <p>a.m., an interview was conducted with Resident #6. She stated she just moved here at the end of last week from her previous nursing home. She stated she was not told why they were moving her. She stated the previous facility did not do any paperwork with this move. She stated they did not ask her permission to move her, they just told her they were going to move her. She stated they gave her no notice and moved her straight away. She stated no one told her if this move was temporary or permanent. She stated she did not want to go. She stated if she had her choice she would move back. Resident #7 Review of the face sheet for Resident #7 revealed the resident was admitted to the facility 02/22/2013. The resident had [DIAGNOSES REDACTED]. Review of a note documented by S3SSD revealed on 07/16/2020 Resident #7 was informed the resident would be moved to a sister facility due to renovation on hall a. Resident and family ok with the move. On 07/21/2020 at 9:04 a.m., an interview was conducted with Resident #7. She stated she recently moved to the sister facility at the end of last week. She stated they did not explain why they moved her and did ask her permission to move. She stated they gave her one day's notice. She stated she did not sign any paperwork. She stated if given the choice she would like to return to the original facility. Resident #11 Review of the face sheet for Resident #11 revealed the resident was admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]. Review of the most recent MDS for Resident #11 with an ARD of 06/30/2020 revealed the resident had a BIMS of 15 which indicated the resident was cognitively intact. Review of a note documented by S3SSD revealed on 07/17/2020 Resident #11 transferred to a sister facility due to renovation of the facility. Family was notified of move. Resident was not pleased but he agreed and understood. 07/20/2020 at 1:00 p.m., an interview was conducted with Resident #11. He said he was transferred to the sister facility on 07/16/2020. She said S3SSD worker came to talk to him on 07/16/2020 and told him that he would be transferred so the facility could be renovated and that he would transfer back after the renovation. He said within 2 hours, he was on the transportation van with Resident #33. He said he was a resident at the facility for 4 years. He said he had mental illness and did not do well with change. Resident #11 said he received 2-hour notice prior to being transported to the sister facility. Resident #12 Review of the face sheet for Resident #12 revealed the resident was admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED].</p> <p>Review of the most recent MDS for Resident #12 with an ARD of 06/02/2020 revealed the resident had a BIMS of 13 which indicated the resident was cognitively intact. Review of a note documented by S3SSD revealed on 07/17/2020 Resident #12 transferred to a sister facility due to renovation of the facility. Family was notified of move. Resident and family ok with move. On 07/17/2020 at 3:55 p.m., an interview was conducted with Resident #12. He stated he was transferred on 07/16/2020. He stated he was not informed why they were transferring him. He stated they did not get his permission and they just started moving him. He stated he had been at the facility for over a year. He stated he did not want to move to their sister facility. He stated he did not know if his family knew about his move to this facility. He stated he was unsure if it was temporary. He stated he could not recall signing any forms for the transfer but he could say he was notified and moved on the same day. He stated there was nothing wrong with his room. He stated he wanted to return to the previous facility which was his home. Resident #13 Review of the face sheet for Resident #13 revealed the resident was admitted to the facility on [DATE]. The resident had [DIAGNOSES REDACTED]. Review of the most recent MDS for Resident #13 with an ARD of 04/21/2020 revealed the resident had a BIMS of 14 which indicated the resident was cognitively intact. Review of a transfer note documented by S3SSD revealed on 07/16/2020 Resident #13 and family were informed that hall a will be under renovation and resident will move to their sister facility. Resident was not pleased but understood. On 07/17/2020 at 4:00 p.m., an interview was conducted with Resident #13. He stated the facility had been his home for 4 years. He stated he was moved over to their sister facility on 07/16/2020. He stated it was done quickly and he was not given any advance notice. He stated it made him feel lost. He stated they just came in and told him he would be going over to another facility and in less than 6 hours' time, he was moved. He stated there was nothing wrong with his room, which had no damages or issues. He stated he did not sign any paperwork. He stated they asked if he wanted them to call his family and he told them they could if they wanted to. He stated he hadn't spoken to his family since this move. He stated he was told this would be temporary and if given the choice he would prefer to be back in his home. Resident #14 Review of the face sheet for Resident #14 revealed the resident was admitted to the facility on [DATE] and had a Primary [DIAGNOSES REDACTED]. Review of the most recent MDS with an ARD of 05/29/2020 for Resident #14 revealed the resident had a BIMS of 15 which indicated the resident was cognitively intact. Review of the transfer note for Resident #14 revealed no documentation the resident was consulted with prior to transferring to the sister facility. On 07/21/2020 at 8:47 a.m., an interview was conducted with Resident #14. She stated she had been at the facility for [AGE] years after she suffered a stroke. She stated they told her in a kind way she had to go. She stated they had to move her because a water pipe busted and had to renovate. She stated she did not plan to go back. She stated they notified her the same way she was transferred. She stated there was nothing wrong with her room at the facility. She stated she was told a pipe broke and there was some water damage in another area but her room was unaffected. Resident #17 Review of the face sheet for Resident #17 revealed the resident was admitted to the facility on [DATE]. The resident had a primary [DIAGNOSES REDACTED]. Review of the transfer note documented by S3SSD revealed 07/17/2020 Resident #17 was transferred to a sister facility in stable condition. On 07/21/2020 at 9:11 a.m., an interview was conducted with Resident #17. She stated she was just recently transferred but did not remember the date. She stated the staff did not tell her why she was being moved and did not ask her permission. She stated they just told her she had to move. She stated she did not sign any paperwork. She stated they moved her the same day she was given notice. She stated she was not happy with the move and she wanted to be back at the other facility. Resident #20 Review of the face sheet for Resident #20 revealed the resident was admitted to the facility on [DATE]. The resident had a primary [DIAGNOSES REDACTED]. Review of the most recent MDS for Resident #20 with an ARD of 06/16/2020 revealed the resident had a BIMS of 14 which indicated the resident was cognitively intact. Review of the transfer note (recorded as a late entry on 07/20/2020 at 12:39 p.m.) for Resident #20 revealed 07/17/2020 Resident #20 and family were informed of the transfer to the sister facility due to renovation. Resident/Family was ok with transfer. Family asked When will the resident return back? She was informed of being unsure of returning but resident will return back to the facility and a follow-up will be done. On 07/17/2020 at 4:15 p.m., an interview was conducted with Resident #20. She stated she had been at the facility for many years. She stated she was notified 2-3 days' prior of her transfer to the sister facility. She stated she understood this move to be temporary. She stated it was stressful but understood they needed to do some renovations. She stated her family had been notified about this move. She stated she was making the best of things as she can. She stated there was nothing wrong with her room at the other facility. She stated if she had the choice, she would like to go back to her previous facility. Resident #33 Review of the face sheet for Resident #33 revealed the resident was admitted to the facility on [DATE] and had a primary [DIAGNOSES REDACTED]. Review of the most recent MDS for Resident #33 with an ARD of 05/26/2020 revealed the resident had a BIMS of 13 which indicated the resident was cognitively intact. Review of a transfer note documented by S3SSD revealed Resident #33 was transferred to a sister facility on 07/17/2020 due to renovation of the hall a. Family was notified and agreed to move. On 07/21/2020 at 9:18 a.m., an interview was conducted with Resident #33. He stated he was moved from his previous facility at the end of the last week. He stated they told him the reason why they were moving him was because they were remodeling. He stated he did not receive prior notice. He stated they just came in to his room, told him and moved him. He stated there was no paperwork. He stated he did not have a choice and they did not ask his permission. He stated he had been at the previous facility for years and it was his home. He stated he did not want to move to their sister facility. He stated now he would not move back because it would be too much on him. Review of the records for Resident #1, #6, #7, #11, #12, #13, #14, #17, #20 and #33 revealed there was no documentation the residents were notified 30 days prior to their transfer to the sister facility. An interview was held with S6Lessor on 07/20/2020 at 2:07 p.m. He stated he was the manager for the company that owned the facility. He stated he spoke to S12Corp on 07/15/2020 and was never given any indication last week they were going to renovate the facility. He stated part of the lease agreement with the management company was they were to notify them prior to doing any major renovations. He stated they were also not told about them transferring the residents out to their sister facility. He stated if S12Corp would have talked to him about the renovations, they would have had a conversation on how to accommodate the residents because that would have been the priority. He stated they never obtained their consent to renovate and he further stated, I don't know if we would have approved it anyway. He also confirmed it was not disclosed to him by the facility there was a fire on 07/06/2020. An interview was held with S3SSD on 07/21/2020 at 11:30 am. She confirmed Resident #1, Resident #6, Resident #7, Resident #11, Resident #12, Resident #13, Resident #14, Resident #17, Resident #20 and Resident #33 were all transferred on either 07/16/2020 or 07/17/2020. She confirmed they were not given a 30-day notice prior to their transfer. She stated she was told to inform them of their transfer due to renovations. She stated they were supposed to be complete with transfers of the residents on today, 07/21/2020. She stated they stopped the transfers on</p>		

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F 0623 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>(continued... from page 2) Friday 07/17/2020 but she was unsure why. She stated she did not know when the renovations were going to start. She stated she never saw anyone in the building to assess the facility for renovations. S3SSD also confirmed none of the residents liked the transfers. She stated the residents were ok as long as they knew they were going to eventually come back. She stated she was never told the residents were being transferred due to an emergency. An interview was held with S7RVPO on 07/20/2020 at 3:12 p.m. She confirmed there were no official bids for the renovations the facility. She stated she was told by S12Corp they wanted to get all of the residents out to decrease their exposure. She stated S12Corp did not elaborate on what would be done. When asked why the residents were not provided a 30-day notice with reason for their transfer, she stated it was an emergency because of the fire the facility recently had on 07/06/2020. When asked if there was someone that deemed it an emergency to transfer the residents out, she stated the Fire Marshall came in and wrote a report. Review of the documentation by the fire department regarding the fire that was investigated in the facility on 07/06/2020 revealed no documentation indicating the residents needed to be transferred off of hall a immediately for an emergency to renovate the facility.</p>		
F 0885 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Based on record review and interviews, the facility failed to ensure residents' responsible party were notified of positive COVID-19 cases in the facility by the next calendar day at 5:00 p.m. The facility had a census of 93 residents. Findings: A telephone interview was conducted with Resident R9's daughter on 07/21/2020 at 3:35 p.m. She stated she received a letter by mail once a week like clockwork from the facility detailing COVID-19 activities in the facility. Review of the facility's COVID-19 tracking form for Residents revealed in part: Resident R10 COVID Positive Test Date- 05/26/2020, Resident R11 COVID Positive Test Date- 05/14/2020, Resident R12 COVID Positive Test Date- 05/19/2020, Resident R1 COVID Positive Test Date- 06/17/2020, Resident R2 COVID Positive Test Date- 06/17/2020, Resident R8 COVID Positive Test Date- 06/21/2020, Resident R3 COVID Positive Test Date- 06/21/2020, Resident R4 COVID Positive Test Date- 06/21/2020, Resident R5 COVID Positive Test Date- 06/21/2020, Resident R6 COVID Positive Test Date- 06/25/2020, Resident R13 COVID Positive Test Date- 06/23/2020, Resident R7 COVID Positive Test Date- 06/22/2020, Resident #32 COVID Positive Test Date- 06/25/2020. Review of the facility's Facility Staff Tracker-Coronavirus revealed in part: S9CNA COVID Positive Test Date- 05/13/2020, S10CNA COVID Positive Test Date- 06/27/2020, S11CNA COVID Positive Test Date- 07/09/2020, S8AD COVID Positive Test Date- 07/10/2020. An interview was conducted with S1ADM on 07/21/2020 at 11:45 a.m. She stated a letter detailing the facility's COVID activities including new positive COVID-19 tests was mailed to the residents' responsible party weekly. She verified each residents' responsible party was not notified of Residents #32, R1, R2, R3, R4, R5, R6, R7, R8, R10, R11, R12, and R13 positive COVID-19 test results by the next calendar day at 5:00 p.m. She verified each residents' responsible party was not notified of employees S8AD, S9CNA, S10CNA and S11CNA's positive COVID-19 test results by the next calendar day at 5:00 p.m. A telephone interview was conducted with S7RVPO on 07/22/2020 at 11:02 a.m. She stated the company interpreted the rule for notifying residents and their responsible party of positive COVID-19 test results by the next calendar day at 5:00 p.m. was for the initial positive COVID-19 case only and all subsequent positive COVID-19 cases could be updated in the weekly notification. She verified the residents' responsible party was not notified of Residents #32, R1, R2, R3, R4, R5, R6, R7, R8, R10, R11, R12, and R13 positive COVID-19 test results by the next calendar day at 5:00 p.m. She verified the residents' responsible party was not notified of employees S8AD, S9CNA, S10CNA and S11CNA's positive COVID-19 test results by the next calendar day at 5:00 p.m.</p>		