STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032124	A. BUILDING: _____ B. WING _____	C 02/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Durham County Department of Social Services conducted an annual survey and complaint investigation on February 10-12, 2016 and on February 16, 2016.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record review, the facility failed to supervise 1 of 1 sampled residents (Resident #2) who lived in the Special Care Unit (SCU)/Garden Place who was known to fall while in the "beauty parlor." The findings are: Review of Resident #2's current FL-2 dated 6/9/15 revealed: -The resident's diagnoses included Alzheimer's dementia, arteriosclerotic dementia, dementia in other diseases, glaucoma and high blood pressure. -The resident was semiambulatory and was constantly disoriented. -Under the current and recommended level of care domiciliary was checked and SCU was hand written under other.	D 270		

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Review of Resident #2's Resident Register revealed:
-The resident was admitted to the facility on 1/9/15.
-The resident was discharged from the facility on 12/22/15, because the resident's Power of Attorney was not satisfied with the medical and personal care.

Review of Resident #2's Care Plan dated 6/8/15 revealed the resident ambulated with a walker, had a history of falls, was a wanderer, was always disoriented and staff were to assist the resident as needed when transferring.

Review of Resident #2's Resident Service Plan dated 11/10/15 revealed the resident was fall risk.

Review of Resident #2's Licensed Health Professional Support tasks review dated 10/8/15 revealed:
-The resident had a fall on 9/24/15.
-The resident went to the emergency room (ER) and had a skin tear to the forehead and had facial bruising.

Review of Resident #2's Incident Report dated 9/24/15 (no time of incident documented), which was completed by a Supervisor revealed:
-The resident was in the "beauty parlor" getting ready to get his hair done.
-The "resident fell asleep in the chair and fell forward."
-The resident hit his forehead on the floor and had a tear to the front of the head.
-The resident was sent out to the local hospital.
-The resident's blood pressure was 149/63, the pulse was 72 and the temperature was 98 degrees Fahrenheit.

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-The resident's family member was contacted on 9/24/15 at 10:10 a.m. and the resident's primary care physician was contacted via fax.

Review of Resident #2's progress notes revealed:
- There was an entry dated 9/24/15 at 11:00 a.m. by the same Supervisor, who completed the incident report on 9/24/15.
-The resident was sitting in the beauty parlor and fell asleep.
-The resident fell on the floor and hit his head.
-The resident was sent to the local ER.
-The family and primary care physician were notified.

Review of Resident #2's record revealed there was no hospital discharge papers in the resident's record.

Interview with a Personal Care Aide (PCA)/Medication Aide (MA) on 2/12/16 at 12:35 p.m. revealed:
-If a resident fell, staff was supposed to check the resident to make sure the resident was fine and get the nurse or a Supervisor.
-When residents from the SCU had gone to the beauty parlor, staff was supposed to be in the parlor with the resident to assist the resident as needed.
-If a PCA needed to leave the beauty parlor, the PCA should not leave until another PCA had come to relieve the staff.

Telephone interview with the facility's beautician on 2/12/16 at 1:39 p.m. revealed:
-She had been working as the facility's beautician for the past two years.
-She did residents' hair at the facility on Wednesdays or Thursdays.
-If a resident comes to the beauty parlor from

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SCU, the resident was escorted by a nurse or an aide.
-Sometimes staff stayed with the resident and sometimes staff did not stay with the resident.
-If she was finished with the resident's hair, she either walked the resident back to SCU or asked for staff to walk the resident back to SCU.
-She had cut Resident #2's hair twice at the facility's beauty parlor.
-The second time she had cut Resident #2's hair was in 2015. She could not remember the date.
-A staff member who worked in SCU had brought Resident #2 to the salon to get his hair done.
-She could not remember the staff person name (male).
-The staff person left to go and get another resident.
-The beautician had three other residents in the parlor.
- She had finished Resident #2's hair and the resident was sitting in a chair waiting for staff to escort the resident back to SCU.
-Resident #2 had fell asleep and kept leaning forward in the chair. She had to wake the resident up three times and tell the resident to sit back in the chair.
-Between 10:30 a.m. to 11:20 a.m. she had went to shampoo another resident's hair and she heard Resident #2 fall.
-The resident hit the floor and was curled up in a "fetal position."
-The resident hit his forehead.
-She went to go and get the laundry staff person, who was next door in the laundry room, and told the laundry staff person to get some help.

Interview with a Laundry staff person on 2/16/16 at 12:50 p.m. revealed:
-At the facility, she used to work as a PCA, but she no longer worked as a PCA.

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D 270	Continued From page 4 -Currently, she worked as laundry staff. -Sometimes staff may ask her to monitor a resident to relieve staff, but she had not been asked to monitor Resident #2 on 9/24/15. -On 9/24/15 between 10:00 a.m.-10:30 a.m., she was on her way to the janitor's closet, which was across the hall from the beauty parlor, and the beautician asked her to help her get Resident #2 up. -When she saw the resident, the resident had turned and was laying on the right side. -The resident's face was towards the door. -Blood was coming from the resident's forehead. -The resident did not complain of pain. -She and the beautician turned Resident #2 over so the resident could lie on the back. -The laundry staff person sat with Resident #2 on the floor for 10 minutes until the Senior Garden Place Coordinator relieved her. -She did not know Resident #2 was in the beauty parlor until the fall on 9/24/15. Telephone interview with the former Senior Garden Place Coordinator on 2/16/16 at 6:47 p.m. revealed: -When a resident in SCU went to the facility's stylist at the beauty salon, the resident was accompanied by staff. -Staff stayed at the beauty salon until the resident was finished. -If staff needed to leave the resident, staff called for another staff member to come and help relieve the staff member. -On the morning of 9/24/15, she had taken Resident #2 to the facility's beauty salon to get a haircut. -She asked a laundry or housekeeping staff, who was also a PCA and was in the hall, to watch Resident #2 while she went back to SCU to get another resident to bring to the beauty salon.	D 270		

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D 270	Continued From page 5 -She was unsure if it was a laundry staff or housekeeper. -The laundry staff or housekeeper came in the salon and sat with Resident #2. -The former Senior Garden Coordinator went to the unit after the staff person came to relieve her. -When she returned to the beauty parlor, she saw a MA or the laundry staff person on the floor with Resident #2 taking the resident's vital signs. -She could not remember which staff was on the floor with Resident #2. -Resident #2 had a bruise on the head. -The fall happened within three to five minutes after she had left the beauty parlor. -She did not know if the laundry or housekeeper staff left the resident alone in the beauty parlor with the beautician or not. -The Emergency Medical Services (EMS) was called, Resident #2's Power of Attorney (POA) was called, the resident went to the hospital and an incident and accident report was completed. -She could not remember how long Resident #2 stayed in the hospital. She thought the resident was in the hospital for one day. Interview with the Supervisor on 2/12/16 at 2:56 p.m., who completed the incident report and progress note on 9/24/15, revealed: -If a resident from SCU was at the beauty parlor, facility staff was supposed to stay with the resident the whole time until the beautician was finished with the resident. -The residents' from SCU could not be left unsupervised while the residents' was in the beauty parlor. -If staff needed to be relieved from the parlor, staff were supposed to call for another staff to relieve them. -Resident #2 was a falls risk. -She completed the incident report on 9/24/15 for	D 270		

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D 270	Continued From page 6 Resident #2. -She was working as the MA in the Assisted Living on 9/24/15. -On 9/24/15, it was reported Resident #2 had fallen asleep in the beauty parlor and had fell forward to the floor. -She was coming around the corner heading towards the hall where the beauty parlor was located and a MA called her. -When she arrived at the parlor, the two SCU Coordinators were at the beauty parlor with Resident #2. Interview with the same Supervisor on 2/16/16 at 12:11 p.m. revealed: -Resident #2 had fallen out of the chair in the beauty parlor next to the wall on the left side of the parlor near the entrance of the parlor. -Resident #2 was laying on the left side after the fall. Staff repositioned the resident to lay on the back. Observation of the beauty parlor on 2/16/16 at 12:11 p.m. revealed: -The parlor was located in the assisted living area on the hall leading to the SCU. -The parlor's entrance was next to the laundry room, which was about 4-5 feet apart and across the parlor's entrance door was the janitor's closet. -The entrance of the parlor had chairs to the right and left of the room. -On the left side of the room, was at least four chairs lined side by side. -The first chair was four to five feet from the entrance door and was by the wall. Interview with a second MA on 2/16/16 at 10:54 a.m., who worked first shift (7-3) on SCU as MA on 9/24/15, revealed: -If a resident from SCU went to the facility's	D 270		

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beautician, the PCA or MA took the resident to the beauty parlor and sat with the resident until the beautician was finished with the resident.
-If staff needed relief, the staff person should get staff to sit with the resident.
-When the beautician came to the facility, the MA usually assigned staff to assist the residents from the SCU to the beauty parlor.
-September 2015 between 10:30 a.m. and 11:00 a.m., Resident #2 had a fall in the beauty parlor.
-She was in the SCU at the time of the fall.
- Someone came to the SCU and told her Resident #2 was sitting in the chair in the beauty parlor and had fallen out of the chair.
-She could not remember the name of the staff who reported the incident to her.
-She went to the Assisted Living area and took Resident #2's vital signs.
-Resident #2 was bleeding from the forehead. The resident denied pain.
-Staff assisted Resident #2 off the floor, the resident's family member was called, EMS was called and the resident was sent to the local hospital.
-She thought Resident #2 was in the hospital overnight, but she was unsure.
-The Supervisor completed the incident report.
-She could not remember who else was working during the shift when the resident had fallen.

Telephone interview with Resident #2's POA on 2/10/16 at 3:55 p.m. revealed:
-The POA came to the facility daily to see the resident.
-The POA received a call from someone at the facility who informed the family member the resident had fallen out of the chair at the beauty parlor.
-The POA could not remember the time of the call.

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D 270	Continued From page 8 -The POA was told the beautician was sweeping the floor when the resident fell on the floor. The resident fell face first on the floor. -The resident was discharged from the facility on 12/22/15, because the POA was not pleased with the resident's care while the resident was at the facility. Review of Resident #2's progress notes revealed: -An entry dated 9/24/15 at 7:00 p.m., revealed the resident was "at baseline" and there was no bleeding. The resident did not have any new orders. -An entry dated 9/25/15 at 6:00 p.m. by a Supervisor, revealed the resident had bruises on the forehead and face from the fall. The resident had not complained of pain. -An entry dated 9/27/15 at 10:45 p.m. by the same Supervisor, revealed the resident's face was "the same." The resident did not complain of pain. -An entry dated 9/29/15 at 7:00 a.m. by a second Supervisor, revealed the bruising to the forehead had moved "down to the resident's eyes." -An entry dated 10/13/15 at 10:00 a.m. by the former SCU Coordinator revealed, the resident's bruising was clearing. "There were no open areas." The resident had not complained of bruising. Interview with the Senior Garden Place Coordinator on 2/16/16 at 1:10 p.m. revealed: -She was hired and started working at the facility as the SCU Coordinator on 2/8/16. -She was still in training and learning the facility's policies and procedures. -She was unsure what the policy was for residents in SCU going to the facility's beautician. -She thought staff had to walk a resident to the beauty salon, but she was unsure if someone had	D 270		

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D 270	Continued From page 9 to stay with the resident while the resident was in the salon. Interview with Resident Care Coordinator (RCC) on 2/16/16 at 1:15 p.m. revealed: -If a resident from the SCU got their hair done in the beauty parlor by the facility's beautician, a PCA sat with the resident in the salon or stood in the hall. -If the PCA needed relief, the PCA called either another PCA or MA to sit with the resident. -She did not know if another PCA or MA relieved the staff who left Resident #2 in the beauty parlor. Interview with the Regional Nurse on 2/16/16 at 1:33 p.m. revealed she did not know the policy on supervising residents from SCU in the beauty parlor. Interview with the Administrator on 2/16/16 at 2:11 p.m. revealed: -When a resident from SCU goes to the beauty parlor, a PCA or MA should escort the residents to the beauty parlor and stay with the resident the whole time the resident was in the parlor. -If the PCA or MA needed to be relieved, staff should contact another PCA, MA, the RCC, SCU Coordinator or Administrative staff to come and watch the resident. -The facility had housekeepers and laundry staff who were PCA's and were qualified as relief staff to monitor residents in the beauty parlor. -On 9/24/15, Resident #2 was at the beauty parlor. It was reported the resident fell asleep and fell on the floor. -She did not know if the resident fell forward and hit the head on the floor or fell to the side. -The resident had a small cut on the forehead. -When the resident fell, the former Senior SCU Coordinator and a caregiver was standing in the	D 270		

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D 270	Continued From page 10	D 270		

hall. She could not remember who the other caregiver was who was standing in the hall.
-After Resident #2 fell on 9/24/15, EMS was called and the resident went to the hospital on 9/24/15 and returned on the same day.
-Before the resident had fallen in the beauty parlor on 9/24/15, it was reported the resident kept falling asleep in the chair. The beautician and the caregivers kept telling the resident to wake up.
-The resident was not a fall risk at the time of the fall.
-The former Senior Garden Place Coordinator and the Guardian Place Coordinator no longer worked at the facility.

Resident #2's primary care physician could not be reached by the end of the survey.

The facility submitted a Plan of Protection dated 2/16/16, as follows:
-Staff will continue to supervise residents in the beauty parlor, based upon the resident's needs.
-If a resident who lived in the Special Care Unit (SCU)/Garden Place was going to the beauty salon, staff will supervise the resident while the resident was in the beauty parlor and upon return to SCU.

An Addendum to the Plan of Protection dated 2/24/16, was as follows:
-The management team will assure residents are monitored by staff from SCU, while the residents were in the beauty parlor with the facility's beautician.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 17, 2016

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D912	Continued From page 11	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observations, interviews and record review, the facility failed to supervise 1 of 1 sampled residents (Resident #2) who lived in the Special Care Unit (SCU)/Garden Place who was known to fall while in the "beauty parlor." [Refer to Tag D270, 10A NCAC 13F .0901(b). (Type A2 Violation)]	D912		