STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010005	A. BUILDING: _____ B. WING _____	10/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(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 Brunswick County Department of Social Services conducted an annual survey from 10/04/17-10/06/17.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 3 of 6 staff sampled (A, B, and C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) prior to employment in the facility. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A's hire date was documented as 01/03/17. -Staff A was hired as a Personal Care Aide and was also employed as a Medication Aide. -There was documentation of an HCPR inquiry for Staff A dated 01/24/17 with no substantiated findings. Staff A was not available for interview on the afternoon of 10/06/17. Refer to the interview with the Administrator and Director of Clinical Services on 10/06/17 at 1:40pm.	D 137	D137 10A NCAC 13F .0407 a5 Community Executive Director and/or designee will conduct a 100% personnel file audit to ensure all registry verifications are completed. Executive Director and Administrative Assistant were retrained on 10/6/17 as per the Regulation and will have documentation in place of no substantiated findings on NC HCPR upon hire. Executive Director and/or designee will review all new hire paperwork weekly, if staff are hired in that time frame, to ensure NC HCPR documentation is in place. Regional Director of Operations will conduct random audits quarterly to ensure regulation is in compliance. Completion Date:	11/30/17
			D139 10A NCAC 13F .0407 a7 Community Executive Director and/or designee will conduct a 100% personnel file audit to ensure all criminal background checks are completeed. Executive Director and Administrative Assistant will be retrained as per the Regulations and will have documentation in place on each Team Member to ensure all criminal background checks have been completeed upon hire. Executive Director and/or designee will review all new hire paperwork weekly, if staff are hired during that time frame, to ensure criminal background checks have been completed on or before start date. Regional Director of Operations will conduct random audits quarterly to ensure regulation is in compliance. Completion Date:	11/30/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11.2.17

POC reviewed/accepted JJ 11/2/17

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D 137	Continued From page 1 2. Review of Staff B's personnel record revealed: -Staff B's hire date was documented as 05/09/17. -Staff B was employed as a Medication Aide. -There was documentation of an HCPR inquiry for Staff B dated 05/24/17 with no substantiated findings Interview with Staff B on 10/06/17 at 11:25am revealed: -She was hired in May 2017 after moving to North Carolina. -She completed her MA training and passed the MA test in June 2017. -As far as she knew, she had all of the required training and credentials. Refer to the interview with the Administrator and Director of Clinical Services on 10/06/17 at 1:40pm.	D 137	**D161 10A NCAC 13F .0504 a** LHPs identified as a deficient practice during survey were addressed immediately. RCD and Nurse Consultant were retrained on rule area by the Director of Clinical Services on 10/5/17 to ensure ongoing compliance. RCD and/or Regional Nurse will review all current resident LHPs to ensure rule area is met on or before 11/30/17. RCD will review ongoing all new LHPs weekly to ensure rule areas are being met. Regional Nursing and/or designee will conduct quarterly random audits to ensure ongoing compliance of the rule area. Completion Date:	11/30/17
	3. Review of Staff C's personnel record revealed: -Staff C's hire date was documented as 04/25/17. -Staff C was employed as a Personal Care Aide (PCA). -There was documentation of an HCPR inquiry for Staff C dated 06/08/17 with no substantiated findings. Interview with Staff C on 10/05/17 at 3:45pm revealed she was hired in April 2017 as a PCA and was currently in training to become a Medication Aide. Refer to the interview with the Administrator and Director of Clinical Services on 10/06/17 at 1:40pm. Interview with the Administrator and Director of Clinical Services on 10/06/17 at 1:40pm revealed:		**D358 10A NCAC 13F .1004a** Community RCD will retrain all medication staff with regards to the rule area as well as not leaving any medications/creams for self-administration unless informed that they can do so per physician order and Carillon policies and procedures. RCD/RCC/GPC and/or ED will conduct resident room checks weekly to ensure medication staff are remaining in compliance. Regional Nursing and/or RDO will conduct random audits quarterly to ensure staff are compliant with rule area and Carillon policies and procedures. Completion Date:	11/30/17

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D 137	Continued From page 2 -The only documentation of HCPR screenings for Staff A, Staff B, and Staff C were the ones in their records. -Additional HCPR screens "could've been run" for the three staff, but the facility did not have documentation of such. -The Administrator's Assistant was responsible for performing HCPR screenings for staff upon hire. -There had been a period of "transition" between the previous Administrator's Assistant to the current Administrator's Assistant (before the current Administrator took over responsibility of the facility). -The facility conducted random audits of staff personnel records. -During random audits, it was identified that HCPR screenings for Staff A, Staff B, and Staff C were not documented; the HCPR screenings were completed at that time.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 staff sampled (Staff A) had a criminal background screening in accordance with G.S. 131D-40 upon hire. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 01/03/17 and had worked as a Personal Care Aide and Medication Aide.	D 139		

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D 139	Continued From page 3 -There was documentation of a criminal background screening dated 09/28/17. Staff A was not available for interview on the afternoon of 10/06/17. Interview with the Administrator and Director of Clinical Services on 10/06/17 at 1:40pm revealed: -Staff A was hired in January 2017. -Staff A had a criminal background screening completed in September 2017. -The Administrator's Assistant was responsible for performing criminal background screenings for staff upon hire. -There had been a period of "transition" between the previous Administrator's Assistant to the current Administrator's Assistant (before the current Administrator took over responsibility of the facility). -The facility conducted random audits of staff personnel records. -During a random audit, it was identified that Staff A did not have the criminal background screen upon hire; therefore, Staff A's criminal background screening was completed after completion of the audit.	D 139		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of	D 161		

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D 161	Continued From page 4 Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 2 of 2 non-licensed staff sampled (Staff A, Staff C) had been competency validated for licensed health professional support (LHPS) tasks including assistance with applying and removing a leg brace for a resident prior to the staff performing thes task. The findings are: Observation of Resident #2 on 10/04/17 at 4:30pm revealed: -He was in the front patio area near the main entrance. -He was sitting in his wheelchair and had a leg brace on his left lower leg. Observation of Resident #2 on 10/05/17 at 11:10am revealed: -He was in his room in his recliner. -He was not wearing his left leg brace. -He had left side weakness with limited use of his left arm and hand; the finger of this left hand were closed unless he used his right hand to open them. Interview with Resident #2 on 10/05/17 at 11:10am revealed: -His left side was "weak" due to a stroke he had five years ago. -He began to use a left leg brace after his stroke; he was supposed to wear the leg brace every day.	D 161		

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D 161	Continued From page 5 -Without the use of the brace, his left leg was more "unstable." -He was not able to put on his left brace himself due to his left sided weakness. -The staff on duty the first thing in the morning, (near breakfast time) applied his brace to his left leg and removed the brace as needed. -The process staff used when applying the brace to his leg was as follows: staff applied lotion, applied a sock, applied the brace, and assisted him with putting on his shoes. 1. Interview with Staff A on 10/05/17 at 3:22pm revealed: -Resident #2 could not apply his leg brace; staff applied the brace. -She applied Resident #2's leg brace independently, as needed. -She had not been observed or validated by a Registered Nurse (RN) or any other staff prior to applying Resident #2's leg brace, but the resident would tell her (and other staff) if the brace was not applied correctly. Review of Staff A's personnel record revealed: -Staff A was hired 01/03/17 as a Personal Care Aide (PCA) and Medication Aide (MA). -There was an LHPS task validation for Staff A signed by an RN and dated 02/24/17. -"NA" (not applicable) was documented on the LHPS validation form in the box beside the task of application and removal of prosthetic devices. Refer to the interview with the Administrator, Resident Care Director, Director of Clinical Services, and Regional Director of Operations on 10/06/17 at 2:30pm. 2. Interview with Staff C on 10/05/17 at 3:45pm revealed:	D 161		

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D 161	Continued From page 6 -Resident #2 had a leg brace that he wore daily from the time staff got him up in the mornings until it was removed by staff on second shift when he went to bed. -Resident #2 could not physically apply his leg brace by himself. -She applied Resident #2's leg brace independently. -The process she used for application of Resident #2's leg brace was to apply lotion, apply his sock, and apply the brace last. -When she first started working there, a MA showed her how to apply Resident #2's leg brace, but she had not been observed or validated by an RN or physical therapist. Review of Staff C's personnel record revealed: -Staff C was hired 04/25/17 as a PCA. -There was an LHPS task validation for Staff A signed by a RN and dated 04/29/17. -"MT (Medication Aide) present" was documented on the LHPS validation form in the box of the task of application and removal of prosthetic devices. Refer to the interview with the Administrator, Resident Care Director, Director of Clinical Services, and Regional Director of Operations on 10/06/17 at 2:30pm. Interview with the Administrator, Resident Care Director, Director of Clinical Services, and Regional Director of Operations on 10/06/17 at 2:30pm revealed: -Staff applied Resident #2's leg brace. -Staff should be validated on application of the leg brace. -They would assure staff were validated for competency of application of Resident #2's brace.	D 161		

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D 358	Continued From page 7	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based of observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 1 of 5 residents sampled (Resident #2) for a steroid/antifungal cream. The findings are: Review of Resident #2's current FL-2 dated 01/28/17 revealed diagnoses included stroke, atrial fibrillation, left hemiparesis, cardiomyopathy, and hypertension. Review of the physician orders for Resident #2 dated 09/12/ 17 revealed an order for Nystatin with Triamcinolone cream apply to bilateral groin area twice daily. (Nystatin/Triamcinolone is a combination of a steroid and an antifungal used to treat fungal infections of the skin). Interviews with Resident #2 on 10/05/17 at 11:10am revealed: -He had a "rash" in groin that he would follow up with his physician for later that day.	D 358		

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D 358	Continued From page 8 -He was prescribed a cream for the rash; he applied the cream to the rash two to three times a day. -"Sometimes" staff put the cream on his groin area too, but he usually applied the cream. -There was a cup of the cream that was prescribed by his physician in his bathroom now. -A (named) staff gave him the cream "yesterday" (10/05/17). Observation of Resident #2's bathroom on 10/05/17 at 11:30am revealed: -There was less than 15ml of a light yellowish colored cream in a clear disposable medication administration cup sitting on the bathroom vanity county on the left side of the sink. -The cup was covered by a second, larger (drinking size) disposable cup. Observation of Resident #2's bathroom on 10/05/17 at 3:21pm revealed the cream was still on the bathroom vanity counter. A second interview with Resident #2 on 10/05/17 at 4:10pm revealed he used the cream until it ran out (two to three days) and then he would get more from (named) staff. Review of Resident #2's electronic Medication Administration Records (eMARs) for September and October 2017 revealed: -There was an entry for Nystatin/Triamcinolone cream spread topically to bilateral groin twice a day with administration times of 8:00am and 8:00pm. -In September 2017, Nystatin/Triamcinolone cream was documented ad administered twice daily from 09/13/17-09/30/17. -In October 2017, Nystatin/Triamcinolone cream was documented ad administered twice daily	D 358		

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D 358	Continued From page 9 from 10/01/17-10/03/17 and at 8:00am on 10/04/17. Interview with a Medication Aide (MA) on 10/05/17 at 3:22pm revealed: -Resident #2 had "irritation" in his groin area; he had the same type of irritation in the past. -Resident #2 was prescribed Nystatin cream twice daily. -Staff "usually" applied the cream for Resident #2. -If staff was in the room when he was toileting, staff may hold the cup while the resident applied the cream; staff took the cup after he finished applying the cream. -Resident #2 did not have access to the Nystatin cream without staff present; residents were not supposed to keep medications in their room. Telephone interview with Resident #2's physician on 10/05/17 at 4:08pm revealed: -Resident #2 was prescribed Nystatin/Triamcinolone cream for jock itch twice daily. -Resident #2 was probably applying the cream himself to maintain his privacy. -If the resident wanted to apply the cream himself to maintain privacy, it would be better if staff would provide him with the cream twice daily and then dispose of what was left over so the medication was not administered more than twice daily (as ordered). Interview with the Administrator, Resident Care Director, Director of Clinical Services, and Regional Director of Operations on 10/05/17 at 4:45m revealed: -Residents were not supposed to have medications in their room. -The cream should not be left in Resident #2's room.	D 358		

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D 358	Continued From page 10 -They would assure the cream was removed from Resident #2's room and it was administered twice daily, as ordered.	D 358		