

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey and complaint investigation on December 19-22, 2017. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on December 14, 2017.	D 000		
D 162	10A NCAC 13F .0504(b) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (b) Competency validation shall be performed by the following licensed health professionals: (1) A registered nurse shall validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(1) through (28) of Rule .0903 of this Subchapter. (2) In lieu of a registered nurse, a respiratory care practitioner licensed under G.S. 90, Article 38, may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (a)(11), (a)(16), (a)(18), (a)(19) and (a)(21) of Rule .0903 of this Subchapter. (3) In lieu of a registered nurse, a registered pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(8) of Rule .0903 of this Subchapter. (4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a)(22) through (27) of Rule .0903 of this Subchapter.	D 162	A new LHPS skills evaluation was immediately completed with Staff C during the survey. The community will complete an audit of Team Member Files to ensure that LHP competency evaluations have been completed for tasks being performed, whether as a Personal Care Aid (PCA), Medication Technician (MT) or Supervisor in Charge (SIC). The Executive Director (ED) will conduct random audits of personnel files to ensure required validations and supporting documentation are present.	22-Feb-18 and ongoing

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE *CHIEF OPERATIVE OFFICER*

(X6) DATE

STATE FORM

5599

CS6211

If continuation sheet 1 of 97

Reviewed and accepted

mp 2/7/18

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D 162	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure a licensed health professional had competency validated 1 of 4 sampled staff (Staff C) for Licensed Health Professional Support (LHPS) tasks including collecting and testing of fingerstick blood samples (FSBS), medication administration through injection, ambulation using assistive devices that requires physical assistance, and transferring semi-ambulatory or non-ambulatory residents prior to staff performing the tasks. The findings are: Review of Staff C's personnel record revealed: -She was hired as a Medication Aide (MA) on 08/11/17. -She passed the written MA exam on 07/25/17. -She completed the 15 hour MA training on 08/23/17. -There was no documentation a competency validation for Licensed Health Professional Support (LHPS) clinical skills check. Interview on 12/20/17 at 2:30 pm with Staff C revealed: -She had worked at the facility as a MA since August 2017. -She worked almost 40 hours per week. -She performed LHPS tasks such as FSBS, medication administration through injection, providing physical assistance to residents who require assistive devices, and transferring of semi-ambulatory and non-ambulatory each day that she worked. Interview on 12/21/17 at 8:50 am with the Special Care Unit Coordinator revealed: -The LHPS Nurse was the staff who completed	D 162			

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D 162	Continued From page 2 the LHPS tasks checklist with new employees. -Staff should be qualified for the job she performed, and the LHPS tasks checklist was one way of validating qualification. -The Administrative Assistant was the staff responsible for maintaining the personnel records and ensuring all required paperwork was completed. Interview on 12/20/17 at 2:35 pm with the Regional Nurse revealed: -Staff C performed LHPS tasks daily. -No documentation a competency validation for LHPS tasks was found in Staff C's Record. -She had completed a new LHPS tasks checklist with Staff C today when the facility was aware the paperwork was missing. Interview on 12/20/17 at 3:05 pm with the Administrative Assistant revealed: -"I make sure the required paperwork is in the personnel records". -She was unable to locate a LHPS tasks checklist for Staff C prior to the one completed 12/20/17. Interview on 12/21/17 at 4:45 pm with the Interim Administrator revealed the Administrative Assistant was the staff responsible for maintaining personnel records and making sure all required paperwork was completed.	D 162		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care	D 269	The community will educate staff on the expectation of responding to resident call bells as quickly as possible. Additionally, the staff will be educated on resetting the residents' call bell immediately upon responding. The Executive Director	22-Feb-18 and ongoing

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D 269	Continued From page 3 needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure personal care assistance was provided in accordance with the assessed needs of 2 of 7 sampled residents (#5 and #7) by not answering call bells in a timely manner. The findings are: A. Review of Resident #5's previous FL-2 dated 08/16/17 revealed diagnoses of hypertension, cerebrovascular accident in August 2014, spinal stenosis, osteoporosis, right knee osteoarthritis, and peripheral venous insufficiency. Review of Resident #5's current FL-2 dated 12/20/17 revealed: -Resident #5 was ambulatory with a walker or a wheelchair. -Resident #5 required assistance with bathing and dressing. Review of Resident #5's current care plan dated 08/29/2017 revealed: -The resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming and transferring. -One person assistance was listed for toileting and transferring. -Resident was independent with eating after meal setup. Review of Resident #5's Licensed Health Professional Support form dated 9/14/17	D 269	(ED), Resident Care Director (RCD) Resident Care Coordinator (RCC) will monitor to ensure timely responses and will conduct random test to ensure proper response times.	

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D 269	Continued From page 4 revealed: -Resident required assistance with ambulation using both her walker and wheelchair. -Staff competency for transferring and ambulation assistance was validated. -The nurse assessment noted that the resident was mobile with the assistance of one or two staff and needed assistance with transfers to and from wheelchair. Review of Incident Reports for Resident #5 revealed: -A report of an assisted fall in the presence of staff on 8/30/17 with no apparent injuries noted. -A reported fall on 9/02/17 noting that the resident was found on the floor and said she slipped out of her chair, with no noted injuries. -A report on 12/16/17 noting that the resident's chair alarm "went off" in the bathroom and she pulled the emergency cord for assistance. Review of Care Conference Meeting notes dated 9/15/17 revealed: -Resident #5's responsible family member met with the facility's Resident Care Director (RCD) and Executive Director (ED) to discuss the resident's recent falls. -The facility requested a chair alarm for the resident and the family member agreed to provide the alarm. Review of Resident #5's Fall Intervention and Review Request revealed: -There was no date for the form being completed. -The form was faxed to Resident #5's primary care provider on 9/14/17. -There was a request for a chair alarm. -There was a request for physical therapy, occupational therapy, and skilled nursing. -The provider signed the orders approving the	D 269		

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D 269	Continued From page 5 chair alarm and therapies on 9/19/17. Interview on 12/19/17 at 9:32 am with Resident #5 revealed: -She had moved into the facility at the end of August 2017. -She needed assistance transferring from her bed to her wheelchair or armchair. -She usually went to the bathroom herself but occasionally needed help. -Staff helped her with bathing and dressing. -She had a chair alarm on her wheelchair because she had fallen twice when she first moved in. -The chair alarm was "very loud and annoying" when it sounded. -On 12/16/17, in the late evening, she was in the bathroom when her chair alarm "went off." -She waited for "several minutes" for staff to come reset the chair alarm, and when no one came, she pressed her call bell button. -No staff responded to her call bell for at least 30 minutes. -When no one responded, she wheeled herself out into the hallway and waited for staff. The chair alarm was still sounding. -No staff came to reset her chair alarm or respond to her call bell until third shift reported for duty. -The third shift staff person reset her chair alarm and canceled her call bell, and then helped her back to her room to go to bed. -There were "several times" when she had pressed her call bell for assistance with personal care and waited longer than 20 minutes for staff to respond. Review of the facility's call bell log revealed: -Resident #5 pressed her call bell on 12/16/17 at 9:49 pm and it was answered at 10:53 pm, for a	D 269		

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D 269	Continued From page 6 total of 53 minutes. -Resident #5 pressed her call bell on 12/17/17 at 4:45 am and it was answered at 8:52 am, for a total of 247 minutes. -Resident #5 pressed her call bell on 12/19/17 at 5:52 am and it was answered at 7:31 am, for a total of 99 minutes. Refer to confidential interview with a staff member. Refer to interview on 12/21/17 with second shift Medication Aide (MA). Refer to interview on 12/21/17 at 4:57 pm with the Regional Registered Nurse (RN). Refer to interview on 12/22/17 at 9:18 am with Director of Clinical Services (DCS). Refer to interview on 12/22/17 at 12:32 pm with the Regional Director of Operations (RDO). B. Resident #7's current FL-2 dated 2/28/17 revealed: -Diagnoses included Parkinson's disease, benign prostatic hyperplasia, and history of colon cancer. -Personal care assistance needed with bathing, feeding, and dressing. -Resident #7 was semi-ambulatory. -Resident #7 was continent of bowel and bladder. Review of Resident #7's current care plan dated 03/06/2017 revealed that the resident required assistance with eating, toileting, ambulation, bathing, dressing, grooming and transferring. Review of Resident #7's Licensed Health Professional Support form dated 12/18/17 revealed:	D 269		

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D 269	Continued From page 7 -Resident required assistance with ambulation using both his walker and wheelchair. -Staff competency for transferring and ambulation assistance was validated. -The nurse assessment noted that the resident was mobile with the assistance of staff. Interview on 12/21/17 at 3:00 pm with Resident #7 revealed: -He was unsteady walking and standing due to Parkinson's Disease. -He needed staff assistance ambulating with his walker or transferring to and from his wheelchair. -He needed assistance with ambulation for toileting. -Sometimes he used a urinal rather than walking to the toilet if he was in bed or his armchair. -He had to wait longer than 10 minutes for staff to assist him for toileting "at least once a week." -The longest wait recently that he could remember was over 1.5 hours. -He had urinated on himself on the past when staff did not answer his call bell in a timely manner. Review of the facility's call bell log revealed: -Resident #7 pressed his call bell on 12/16/17 at 3:14 pm and it was answered at 6:21 pm, for a total of 186 minutes. -Resident #7 pressed his call bell on 12/16/17 at 7:59 pm and it was answered at 9:20 pm, for a total of 81 minutes. -Resident #7 pressed his call bell on 12/17/17 at 12:57 pm and it was answered at 2:02 pm, for a total of 64 minutes. -Resident #7 pressed his call bell on 12/19/17 at 7:10 am and it was answered at 7:57 am, for a total of 47 minutes. -Resident #7 pressed his call bell on 12/20/17 at 7:30 am and it was answered at 9:05 am, for a	D 269		

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D 269	Continued From page 8 total of 94 minutes. Refer to confidential interview with a staff member. Refer to interview on 12/21/17 at 4:16 pm with second shift Medication Aide (MA). Refer to interview on 12/21/17 at 4:57 pm with the Regional Registered Nurse (RN). Refer to interview on 12/22/17 at 9:18 am with Director of Clinical Services (DCS). Refer to interview on 12/22/17 at 12:32 pm with the Regional Director of Operations (RDO) Confidential Interview with a staff member revealed: -The call bell system worked by sending an alert from the call bell pendant to pagers each MA and personal care assistant (PCA) carried. -To clear the alert, a person had to physically reset the call bell pendant by pressing a pen or pencil into a small button on the back of the box. -Once they cleared the call bell, they could clear the alert on the pager to show that the call had been answered. -They had several residents make complaints to them about second and third shift not answering call bells in a timely manner. -They had residents complain to them about there not being enough staff to meet residents' needs on second and third shift. -They thought the staffing ratios were 1 MA and 2 PCA staff for first and second shift to cover the assisted living side of the facility, which was 2 stories. On third shift, there was 1 MA and 1 PCA to cover both floors. Staffing for the special care	D 269		

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D 269	Continued From page 9 unit was different. -Occasionally staff would get pulled from the assisted living side to help in the special care unit, which could leave the assisted living side short of staff. -They were afraid to question management regarding staffing or resident complaints due to retaliation. Interview on 12/21/17 at 4:16 pm with an evening shift Medication Aide (MA) revealed: -She had been employed at this facility for 2 years. -Residents wore a pendant call bell to alert staff of their needs. -When a resident pressed their call bell, she received a page on the pager she was wearing. -The staff were to respond to the resident within 3 minutes of them pressing their call bell and "I usually do." -She was unaware of any time in which it had taken her longer than 3 minutes to respond to resident. -Once she entered the resident's room, she would use a pen to press the pinhole in the back of the resident's pendant to reset it. -She would then reset her pager. -If she were performing a task that required more than a few minutes, such as bathing, she would notify another staff person and ask them to answer her call bells. -If pendants were misplaced by the resident or if the batteries were running low, the pendant would continue to page the staff even if they had assisted the resident. Interview on 12/21/17 at 4:57 pm with the Regional Registered Nurse (RN) revealed: -She had been employed with this facility since October 2015.	D 269		

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D 269	Continued From page 10 -The floor staff wore pagers that would alert them when a resident pressed their call bell. -Staff were taught to respond to the residents within 10 minutes of them pressing their call bell. -Once they responded to the resident, staff would clear the alert by pressing the pinhole on the back of the resident's pendant and then reset their pagers. -It was the Resident Care Coordinator's (RCC) responsibility to audit the call bell log daily. Interview on 12/22/17 at 9:18 am with Director of Clinical Services revealed: -She was responsible for training new staff on the call bell system. -When residents would press their call bell, staff would be alerted via their pager. -Staff were taught to respond to residents within 10 minutes of them pressing their call bell. -Staff had to physically reset the back of the resident's pendant to clear the page. -The pager would continue to alert staff until they cleared the pendant. Interview on 12/22/17 at 12:32 pm with the Regional Director of Operations revealed: -She was serving as Interim Executive Director at this facility. -Staff were trained to respond to residents within 10 minutes of them pressing their call bell. -It was the RCC's responsibility to review the call bell log each day to ensure residents were being responded to in a timely manner. -The information would also show up on a regional report, but it would still be the responsibility of the RCC to address any concerns. -She was unaware the call bell log indicated residents were waiting greater than 10 minutes. -It would have been the RCC's responsibility to	D 269		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CARILLON ASSISTED LIVING OF HUNTERSVILLE

**250 COMMERCE CENTER DRIVE
HUNTERSVILLE, NC 28078**

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D 269	Continued From page 11 notify her. -The RCC was unavailable for interview.	D 269		
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 B VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 1 of 1 sampled residents with falls (Resident #2). The findings are: Review of Resident #2's current FL-2 dated 09/08/17 revealed: -Diagnoses included Alzheimer's Dementia, lumbago (low back pain) and arthropathy (a disease of the joints). -The resident was documented as being ambulatory with a wheelchair. Review of Resident #2's Care Plan dated 01/30/17 revealed: -The resident required limited assistance with ambulation. -The resident required limited assistance with transfers.	D 270	The community initiated immediate training for staff to ensure interventions prescribed were implemented and monitored ongoing. The RCD and ED will conduct an audit of residents with a history of falls and ensure that proper interventions are reviewed with the residents' respective primary care physician. New orders received will be implemented upon receipt. Staff will be appropriately re-educated on interventions. This will be completed by February 5, 2018. Ongoing, as residents experience falls, an investigation will be completed in an attempt to determine root cause and appropriate interventions will be implemented. Residents with falls will be reviewed weekly by the ED with the RCD and/or RCC to ensure all interventions are implemented and staff are appropriately educated.	5-Feb-18 and ongoing

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D 270	Continued From page 12 Review of the facility's "Fall Intervention Protocol" revealed: -" ...Should a resident be identified as having a higher pattern of falls than what is considered normal for their individual baseline, measures will be implemented for that particular resident in an effort to identify any possible changes in the resident's condition that may contribute to falls and to reduce the potential for future falls." -For any resident with 4 or more falls in 3 months, the Regional Nurse would follow the resident for the next 6 weeks on the "CKI summary" (an internal quality assurance document) to determine if advanced levels of care were necessary. Interview on 12/20/17 at 12:06 pm with the facility's Director of Clinical Services revealed: -The CKI summary referred to in the "Fall Intervention Protocol" was an internal quality assurance document that listed all residents in the building who had falls and was reviewed by the Regional Registered Nurse (RN). -All interventions put into place after a resident's fall would be documented in their record. -She was unable to produce any information that would verify the facility had increased supervision for Resident #2 after having multiple falls. Review of the facility's incident reports and staff notes revealed Resident #2 had 6 falls from 09/04/17 to 11/19/17 as follows: -On 09/04/17 at 10:00 pm, the resident was found lying on the floor next to his bed, he complained of back pain and was sent to the Emergency Department (ED) and X-rays were found to be negative. -On 09/30/17 at 7:00 am, the resident was found in a sitting position on the floor in his room with	D 270		

Division of Health Service Regulation		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	A. BUILDING: _____ B. WING: _____		C 12/22/2017
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
(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 270	Continued From page 13 his pants down and no apparent injury. -On 10/12/17 at 11:00 pm, the resident was found lying on the floor next to his bed, he complained of hitting his head and had a skin tear and was sent to the ED and treated for a skin tear to his head. -On 10/17/17 at 2:55 pm, a Medication Aide (MA) observed the resident stand up from his wheelchair and fall to the floor with no apparent injury. -On 11/16/17 at 3:30 am, the resident was found lying on the floor next to his bed, he complained of back pain and had a skin tear on his head, and was sent to the ED where he was treated for the skin tear. -On 11/19/17 at 10:28 pm, the resident was found on the floor of his bathroom with no apparent injury. Review of Resident #2's Licensed Health Professional Support (LHPS) dated 09/25/17 revealed resident was prescribed physical therapy (PT) for ambulation /safety with start of care date of 09/07/17. Review of the facility's PT notes for Resident #2 revealed he was seen by PT 15 times from 09/07/17 until 10/25/17 when he was discharged. Review of Resident #2's physician's orders dated 10/23/17 revealed an order for bed/chair alarms and hipsters due to a recent onset of a new fall pattern. Interview on 12/20/17 at 8:55 am with the Resident Care Coordinator (RCC) revealed: -She had been employed with this facility since September 2017. -She was aware of Resident #2's falls. -She thought he "should have a chair alarm and	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
(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 270	Continued From page 14 bed alarm, but she would have to look into it further." -Since his falls, staff were providing "supervision at all times." Observations of Resident #2 at various times revealed: -On 12/19/17 at 9:27 am, the resident was observed unsupervised in his room, sitting in a chair, attempting to dress himself with no chair alarm present. -On 12/19/17 at 10:59 am, the resident was observed unsupervised in his room, sitting in a chair with no chair alarm present. Interview on 12/19/17 at 10:34 am with a resident's family member revealed: -She had been at the facility on 12/16/17 to visit her family member. -She became concerned when she witnessed Resident #2 sitting in his wheelchair alone in the dining room with his head down on the table. -Before she could locate a staff person, Resident #2 got up from his wheelchair and pushed it out of the dining room. -Once Resident #2 reached the door of the dining room, a staff person saw him and provided assistance. Observation on 12/20/17 at 9:25 am with the RCC revealed Resident #2 did not have a bed alarm or chair alarm. Interview on 12/20/17 at 10:40 am with the Special Care Unit (SCU) Coordinator revealed: -She had been employed in this role since August 2016. -She was aware of Resident #2's falls. -Every 2 hour checks were performed on all residents.	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER
CARILLON ASSISTED LIVING OF HUNTERSVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
**250 COMMERCE CENTER DRIVE
HUNTERSVILLE, NC 28078**

(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 270	Continued From page 15 -Checks were not documented. -Resident #2 was not checked more frequently than other residents. Interview on 12/20/17 at 10:45 am with the SCU Senior Coordinator revealed: -She had been employed in this role since October 2017. -Since his falls, staff had Resident #2 participating in more activities for supervision. -There was no documentation of when Resident #2 participated in activities. Interview on 12/20/17 at 11:04 am with Resident #2's responsible party revealed: -She visited the facility 1 to 2 times weekly. -She was aware of Resident #2's falls. -The falls usually occurred when he was alone in his room. -She was not aware of any increase in supervision since his falls. -The facility had not communicated to her regarding how they would prevent Resident #2 from falling in the future. Interview on 12/20/17 at 10:15 am with the Regional Director of Operations revealed: -She was serving as Interim Executive Director at this facility. -She was unaware Resident #2 had an order for a bed alarm and chair alarm. -The Resident Care Director (RCD) was responsible for reviewing all physician's orders received, scanning the orders to the pharmacy and transcribing them onto the resident's eMAR. -If an order for chair alarms or bed alarms was received, the RCD was responsible for conducting a care conference with the family and staff coordinators and then adding the information to the resident's service plan so all staff would be	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER
CARILLON ASSISTED LIVING OF HUNTERSVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 16 aware. -The RCD position was currently open. -The former RCD (employed when Resident #2's physician provided the order for the bed alarm and chair alarm) had failed to perform these steps. Interview on 12/20/17 at 2:06 pm with the RN from Resident #2's physician's office revealed: -Resident #2's physician had ordered a bed alarm and chair alarm on 10/23/17 after the facility had reported the resident had an increase in falls. -The chair alarm and bed alarm would help to alert staff when Resident #2 stood up which should help to prevent him from falling. -The physician was unaware the facility had not implemented her orders for the alarms. -Resident #2 was at risk for future falls, injuries and fractures if not wearing the alarms. The facility failed to provide supervision including a bed alarm and chair alarm for Resident #2 which resulted in Resident #2 continuing to have 2 additional falls after 10/23/17. The facility's failure to increase supervision for Resident #2 resulted in him having a total of 6 falls from 09/04/17 to 11/19/17 and was detrimental to the safety and welfare of the resident which constitutes a Type B Violation. The facility provided a Plan of Protection on 12/20/17 as follows: -Training of all staff regarding supervision interventions, as needed, will be immediate. -Regarding falls, the new Resident Care Director (RCD) will maintain fall protocol and implement appropriate safety measures as needed, when identified. -The new RCD will verify all orders timely and ensure implementation.	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078
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D 270	Continued From page 17	D 270		
	CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 5, 2018.			
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the acute and routine health care needs were met for 1 of 5 residents (Resident #3) sampled as related to failure to provide the results for weights and blood pressures ordered weekly. The findings are: Review of Resident #3's current FL-2 dated 07/18/17 revealed diagnoses included hypertension (high blood pressure) and anxiety/depression. 1. Review of Resident #3's current FL-2 dated 07/18/17 revealed there was a physician's order for weekly BP (blood pressure); fax the results to (physician's office fax number). Review of Resident #3's record revealed signed physician orders dated 10/2/17 for check and record blood pressure weekly, fax results to office (phone number listed).	D 273	The RCD will review resident existing orders as well as new orders that require ongoing physician notification. A tracking log is in place to ensure proper and timely notification. This will be reviewed weekly with the community by the Regional Nurse.	22- Feb-18 and ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER
CARILLON ASSISTED LIVING OF HUNTERSVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
**250 COMMERCE CENTER DRIVE
HUNTERSVILLE, NC 28078**

(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 273	Continued From page 18 Review of Resident #3's October 2017 eMAR (electronic Medication Administration Record) revealed: -Check and record blood pressure weekly, fax results to office (phone number) was transcribed on the eMAR and scheduled for 8:00 am on 10/3/17, 10/10/17, 10/17/17, 10/24/17, and 10/31/17. -There was documentation for blood pressure weekly except 10/24/17. -The blood pressures documented were 126/76, 148/70, 125/76, and 135/70, respectively. Review of Resident #3's November 2017 eMAR revealed: -Check and record blood pressure weekly, fax results to office (phone number) was transcribed on the eMAR and scheduled for 8:00 am on 11/7/17, 11/14/17, 11/21/17, and 11/28/17. -There was documentation for blood pressure weekly except 11/28/17. -The blood pressures documented were 112/60, 112/90, and 134/74, respectively. Review of Resident #3's December 2017 eMAR (on 12/20/17) revealed: -Check and record blood pressure weekly, fax results to office (phone number) was transcribed on the eMAR and scheduled for 8:00 am on 12/5/17, 12/12/17, and 12/19/17. -There was documentation for blood pressure weekly. -The blood pressures documented were 112/68, 112/68, and 130/72, respectively. Review of Resident #3's record revealed no documentation the physician had been contacted (faxed), as ordered, regarding blood pressure values for October 2017, November 2017, or	D 273		

Division of Health Service Regulation		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
(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 273	Continued From page 19 December 2017. Interview on 12/20/17 at 10:15 am with the Regional Director of Operations revealed: -She was serving as Interim Executive Director at this facility. -The Resident Care Director (RCD) was responsible for reviewing all physician's orders received and assuring the orders were completed. -The facility had been using a regional staff member that came to the facility 2 to 3 times a week to review physician orders received compared to orders appearing on the residents' electronic Medication Administration Records. Telephone interview on 12/20/17 at 10:26 am with a nurse for Resident #3's physician revealed: -There was no documentation the facility staff had sent the physician's office any blood pressure values for Resident #3 in October 2017, November 2017, or December 2017. -The physician would have expected the facility to follow the order to check blood pressure weekly and fax the value weekly to the office, as ordered. -The physician office had documentation for one physician encounter in October 2017 when the resident was treated for a cold. Based on record review and observation of Resident #3 on 12/20/17, it was determined the resident was not interviewable. Interview on 12/20/17 at 10:40 am with Resident #3's Power of Attorney revealed she was not aware if Resident #3 had an order to check her blood pressure weekly. Interview on 12/20/17 at 11:06 am with the Special Care Unit (SCU) Coordinator revealed:	D 273		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/22/2017
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
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D 273	Continued From page 20 -The SCU medication aide (MA) was responsible for taking a resident's blood pressure and recording on the eMAR. -The Resident Care Director (RCD) or the Resident Care Coordinator (RCC) were responsible to assure clinical services (like taking blood pressures) were completed. -The RCD or RCC would be responsible to notify the residents' physicians if there was an order to notify the physician. Interview on 12/20/17 at 11:20 am with a Medication Aide(MA) revealed: -The MA on duty would be responsible for taking a resident's blood pressure if it appeared on the eMAR. -The RCD or RCC would be responsible for faxing the blood pressure value to the physician if there was an order for the blood pressure value to be faxed. -The MA could fax the physician if there was an order for the blood pressure value to be faxed to the physician. -If the MA faxed the physician, the MA should document in the electronic chart notes or facility Nurse's notes. -She had not faxed a blood pressure value to Resident #3's physician's office. Interview on 12/20/17 at 12:30 pm with the facility's Director of Clinical Services revealed: -The RCD was responsible to assure the physician was faxed according to the orders on the eMAR. -The RCD was responsible to check for physician orders being completed. -The Corporate Nurse came to the facility to do random record audits for medication and treatment orders, but might not have checked to see if the physician was faxed as ordered.	D 273			

Division of Health Service Regulation		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		
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D 273	Continued From page 21 -The Director of Clinical Services had been spending additional time in the facility until the new RCD started working next week (12/26/17). -A corporate nurse had been assigned, during the last 4 weeks, to assume the duties of the RCD and serve as the Interim RCD. -The Interim RCD was on leave and not available for interview. -The Director of Clinical Services was unable to locate documentation Resident #3's physician was faxed weekly weights or blood pressure values as ordered. Interview on 12/20/17 at 2:55 pm with a second shift MA revealed: -The MA was a supervisor. -The RCD or RCC would be responsible for faxing the blood pressure value to the physician if there was an order for the blood pressure value to be faxed. -If a MA notified a physician of a blood pressure, the MA should document the physician notification on the eMAR, in the notes. -If there were notes in Resident #3's eMAR notes for notification regarding weight or blood pressure, then the MA must not have notified the physician. 2. Review of Resident #3's current FL-2 dated 07/18/17 revealed there was a physician's order for check and record weekly weights; fax the results to (physician's office fax number). Review of Resident #3's record revealed signed physician orders dated 10/2/17 for check and record weight weekly, fax results to office (phone number listed). Review of Resident #3's October 2017 eMAR (electronic Medication Administration Record)	D 273		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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D 273	Continued From page 22 revealed: -Check and record weight weekly, fax results to office (phone number) was transcribed on the eMAR and scheduled for 10:00 am on 10/3/17, 10/10/17, 10/17/17, 10/24/17, and 10/31/17. -There was documentation for weights weekly. -The weights documented ranged from 125 to 100 pounds. Review of Resident #3's November 2017 eMAR revealed: -Check and record weight weekly, fax results to office (phone number) was transcribed on the eMAR and scheduled for 10:00 am on 11/7/17, 11/14/17, 11/21/17, and 11/28/17. -There was documentation for weights weekly. -The weights documented ranged from 110 to 95 pounds. Review of Resident #3's December 2017 eMAR (on 12/20/17) revealed: -Check and record weight weekly, fax results to office (phone number) was transcribed on the eMAR and scheduled for 10:00 am on 12/5/17, 12/12/17, and 12/19/17. -There was documentation for weights weekly. -The weights documented were 70, 70, and 76 pounds, respectively. -Resident #3 weighted 88.4 pounds on 12/20/17. Review of Resident #3's record revealed no documentation the physician had been contacted (faxed), as ordered, regarding weekly weight values for October 2017, November 2017, or December 2017. Interview on 12/20/17 at 10:15 am with the Regional Director of Operations revealed: -She was serving as Interim Executive Director at this facility.	D 273		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/22/2017
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
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D 273	Continued From page 23 -The Resident Care Director (RCD) was responsible for reviewing all physician's orders received and assuring the orders were completed. -The facility had been using a regional staff member that came to the facility 2 to 3 times a week to review physician orders received compared to orders appearing on the residents' electronic Medication Administration Records. Telephone interview on 12/20/17 at 10:26 am with a nurse for Resident #3's physician revealed: -There was no documentation the facility staff had sent the physician's office any weight values for Resident #3 in October 2017, November 2017, or December 2017. -The physician would have expected the facility to follow the order to weigh weekly and fax the value weekly to the office, as ordered. -The physician office had documentation for one physician encounter in October 2017 when the resident was treated for a cold. -There was no documentation the physician was concerned about weight for Resident #3. Interview on 12/20/17 at 10:40 am with Resident #3's Power of Attorney (POA) revealed: -She was not aware Resident #3 had an order to weigh the resident weekly. -Resident #3 was not eating very well and sometimes refused to eat. -The facility had called her on occasion regarding Resident #3 not wanting to eat; she would come to the facility to talk to Resident #3 about the importance of eating meals to help control weight loss and keep strength. -The POA had discussed Resident #3's weight and the importance of maintaining good weight with Resident #3's physician within the last 3 months.	D 273			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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D 273	Continued From page 24 -The POA was aware Resident #3 had lost some weight. Interview on 12/20/17 at 11:06 am with the Special Care Unit (SCU) Coordinator revealed: -The SCU medication aide (MA) was responsible for taking a resident's weight and recording on the eMAR. -The Resident Care Director (RCD) or the Resident Care Coordinator (RCC) were responsible to assure clinical services (like taking weights) were completed. -The RCD or RCC would be responsible to notify the residents' physicians if there was an order to notify the physician. Interview on 12/20/17 at 11:20 am with a first shift Medication Aide(MA) revealed: -The MA on duty would be responsible for assuring a resident was weighed if it appeared on the eMAR. -The RCD or RCC would be responsible for faxing the weight to the physician if there was an order for the weight value to be faxed. -The MA could fax the physician if there was an order for the weight value to be faxed to the physician. -If the MA faxed the physician, the MA should document in the electronic chart notes or facility Nurse's notes. -She had not faxed a weight value to Resident #3's physician's office because the RCC or RCD was responsible to complete physician notification of the residents' weights. Interview on 12/20/17 at 12:30 pm with the facility's Director of Clinical Services revealed: -The RCD was responsible to assure the physician was faxed according to the orders on the eMAR.	D 273		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078
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D 273	Continued From page 25 -The RCD was responsible to check for physician orders being completed. -The Corporate Nurse came to the facility to do random record audits for medication and treatment orders, but might not have checked to see if the physician was faxed as ordered. -The Director of Clinical Services had been spending additional time in the facility until the new RCD started working next week (12/26/17). -A corporate nurse had been assigned, during the last 4 weeks, to assume the duties of the RCD and serve as the Interim RCD. -The Interim RCD was on leave and not available for interview. -The Director of Clinical Services was unable to locate documentation Resident #3's physician was faxed weekly weights or blood pressure values as ordered. Interview on 12/20/17 at 2:55 pm with a second shift MA revealed: -The MA was a supervisor. -The RCD or RCC would be responsible for faxing the weight value to the physician if there was an order for the weight value to be faxed. -If a MA notified a physician of a weight, the MA should document the physician notification on the eMAR, in the notes. -If there were notes in Resident #3's eMAR notes for notification regarding weight or blood pressure, then the MA must not have notified the physician.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from	D 276		

Division of Health Service Regulation		(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/22/2017
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142		
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
(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 276	Continued From page 26 a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement physicians' orders for 2 of 5 sampled residents regarding thrombo-embolic deterrent (TED) hose, a chair alarm, bed alarm and hipsters (Resident #2), and compression stockings (Resident #1). The findings are: A. Review of Resident #2's current FL-2 dated 09/08/17 revealed diagnoses included Alzheimer's Dementia, hypertension, lumbago (low back pain) and arthropathy (a disease of the joints). 1. Review of Resident #2's current FL-2 dated 09/08/17 revealed there was a physician's order to provide TED hose every morning and remove every evening. Review of Resident #2's Care Plan dated 01/30/17 revealed the resident required limited assistance with dressing. Review of Resident #2's October 2017 electronic Medication Administration Record (eMAR) revealed: -TED hose were documented as being "on" 27 mornings at 8:00 am and documented as being	D 276	The community initiated immediate training for staff to ensure interventions prescribed were implemented and monitored ongoing, to include but not limited to Ted Hose, Hipsters, chair alarms and bed alarms. Additionally, the community secured necessary Ted Hose, Hipsters, chair alarms and bed alarms identified as missing during the survey for respective residents. The RCD and ED will conduct a review of residents prescribed TED Hose, Hipsters, chair alarms and bed alarms to ensure physician orders are implemented and noted timely and appropriately on the eMAR and/or ePCR. Staff members will be re-educated ongoing, to ensure proper understanding and commitment to implementation. The RCD/ED and/or designee will conduct random audits to ensure ongoing compliance. These residents will be reviewed weekly by the Regional Nurse.	5-Feb-18 and ongoing

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NAME OF PROVIDER OR SUPPLIER
CARILLON ASSISTED LIVING OF HUNTERSVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
**250 COMMERCE CENTER DRIVE
HUNTERSVILLE, NC 28078**

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D 276	Continued From page 27 "off" 18 evenings at 8:00 pm. -TED hose were documented as "missed dose" on 4 mornings and 13 evenings. Review of Resident #2's November 2017 eMAR revealed: -TED hose were documented as being "on" 28 mornings at 8:00 am and documented as being "off" 17 evenings at 8:00 pm. -TED hose were documented as "missed dose" on 2 mornings and 13 evenings. Review of Resident #2's December 2017 eMAR revealed TED hose were documented as being "on" 20 mornings at 8:00 am, including 12/19/17, and documented as being "off" 20 evenings at 8:00 pm. Review of Resident #2's Licensed Health Professional Support (LHPS) assessment dated 9/25/17 revealed documentation Resident #2 was observed with ankle edema to bilateral lower extremities with no TED hose in use. Observations of Resident #2 at various times revealed: -On 12/19/17 at 9:27 am, resident was observed with no TED hose on. -On 12/19/17 at 10:59 am, resident was observed with no TED hose on. -On 12/19/17 at 12:19 pm, resident was observed with no TED hose on. -On 12/19/17 at 3:34 pm, resident was observed with no TED hose on. Observation on 12/19/17 at 3:28 pm of Resident #5's medications on hand revealed there were no TED hose on the medication cart. Observation on 12/19/17 at 3:44 pm with a	D 276		

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

HAL060142

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: _____

B. WING: _____

(X3) DATE SURVEY
COMPLETED

C

12/22/2017

NAME OF PROVIDER OR SUPPLIER

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D 276	Continued From page 28 second shift MA revealed he located an unopened pair of TED hose in Resident #2's chest of drawers. Observation on 12/20/17 at 8:43 am of Resident #2 revealed he was wearing TED hose. Observation on 12/20/17 at 4:10 pm of Resident #2 with a second shift MA revealed: -The resident was wearing TED hose. -Swelling was present in both lower legs. -A deep indentation to the skin was present when the MA pulled the TED hose down. Interview on 12/19/17 at 3:40 pm with the Special Care Unit (SCU) Coordinator revealed: -She had been employed in this role since August 2016. -Personal Care Aides (PCA) were responsible for applying TED hose to residents with physicians' orders. -Medication Aides (MA) were responsible for checking during medication administration times that TED hose had been applied and removed and then documenting on the eMAR. Interview on 12/19/17 at 3:44 pm with a evening shift MA revealed: -He had been employed at this facility for 3 weeks. -He had been trained by another MA at the facility. -He had not observed Resident #2 to have TED hose on since he had been employed. -He was aware Resident #2 had an order for TED hose and had documented them as being "off" on the eMAR. -TED hose would either be kept on the medication cart or in the resident's room. -He was unaware Resident #2 had TED hose.	D 276		

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D 276	Continued From page 29 Interview on 12/20/17 at 11:04 am with Resident #2's responsible party revealed: -She visited the facility 1 to 2 times weekly. -She was unaware Resident #2 had a physician's order for TED hose. -She had never observed TED hose on Resident #2. Interview on 12/20/17 at 8:55 am with the Resident Care Coordinator (RCC) revealed: -PCAS were responsible for applying and removing TED hose for residents with physicians' orders. -MAs were responsible for checking to ensure TED hose had been applied and removed and documenting it on the eMAR. -She was unable to locate any pair of TED hose other than the pair Resident #2 was currently wearing. Interview on 12/20/17 at 8:09 am with a day shift PCA revealed: -She had been employed at this facility for 3 months. -She knew which residents required TED hose because she was told by other staff when she was first trained. -Only 1 resident (named) in the SCU had an order for TED hose. -Resident #2 did not have orders for TED hose. -Day shift PCAs were responsible for applying TED hose. -PCAs did not document anywhere when they applied TED hose. Interview on 12/20/17 at 9:14 am with the day shift MA revealed: -She had been the day shift Supervisor since August 2017.	D 276		

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D 276	Continued From page 30 -PCAs were responsible for applying TED hose. -MAs were responsible for checking during medication administration times to ensure TED hose were applied in the mornings and removed in the evenings and then documenting as such on the eMAR. -If an MA were to find that a resident did not have TED hose applied or removed, they were to ask the PCA to do so, verify it had been done and then document on the eMAR. -She was unsure as to whether Resident #2 wore TED hose. Interview on 12/20/17 at 9:22 am with the day shift PCA revealed: -She had been employed with this facility for 7 months. -She had only observed TED hose on Resident #2 one time since she began working at this facility. -Resident #2's TED hose "were lost a long time ago and I never saw them again." -Whenever a resident's TED hose needed to be replaced, she would notify the MA. -The MA would order them and the agency providing the TED hose would notify the PCAs when they arrived in the facility. -She had notified a MA concerning Resident #2's TED hose being missing, but could not recall who she had notified or when she had notified them. Telephone interview on 12/20/17 at 2:16 pm with the facility's contracted pharmacy revealed: -The facility faxed new physicians' orders to the pharmacy. -The pharmacy was responsible for filling the orders and entering them into the eMAR. -The MAs would be able to see the orders on the eMAR as soon as they were entered. -The pharmacy had dispensed TED hose for	D 276		

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D 276	Continued From page 31 Resident #2 on 5/8/17, 6/27/17 and 12/20/17. Interview on 12/20/17 at 2:06 pm with the Registered Nurse (RN) from Resident #2's physician's office revealed: -Resident #2's physician had ordered TED hose on 05/08/17 due to bilateral lower edema. -The physician was unaware the facility staff were not applying TED hose as ordered. -Resident #2 was at an increased risk of pedal edema if TED hose were not applied as ordered. Interview on 12/20/17 at 2:40 pm with the Regional RN revealed: -The night shift MAs were responsible for ensuring TED hose had been applied and then documenting it on the eMAR at 8:00 am. -The evening shift MAs were responsible for ensuring TED hose had been removed and then documenting it on the eMAR at 8:00 pm. -If TED hose could not be located for a resident, it was the MAs responsibility to either reorder them or notify the RCD so they could reorder them. Refer to interview on 12/20/17 at 2:40 pm with the Regional RN. 2. Review of Resident #2's physician's orders dated 10/23/17 revealed an order for bed/chair alarms and hipsters due to a recent onset of a new fall pattern. Review of the facility's incident reports and staff notes revealed Resident #2 had 6 falls from 09/04/17 to 11/19/17. Observations of Resident #2 at various times revealed: -On 12/19/17 at 9:27 am, the resident was observed sitting in a chair in his room with no	D 276		

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D 276	Continued From page 32 chair alarm present. -On 12/19/17 at 10:59 am, the resident was observed sitting in a chair in his room with no chair alarm present. -On 12/19/17 at 12:19 pm, the resident was observed sitting in his wheelchair with no chair alarm present. -On 12/19/17 at 3:34 pm, the resident was observed sitting in a chair in a common room with no chair alarm present. -On 12/20/17 at 8:43 am, the resident was observed sitting in his wheelchair with no chair alarm present. Observation of Resident #2 on 12/20/17 at 9:25 am with the Regional Care Care (RCC) revealed he did not have a bed alarm or chair alarm. Interview on 12/20/17 at 8:55 am with the RCC revealed: -She was aware of Resident #2's falls. -She thought he "should have a chair alarm and bed alarm, but she would have to look into it further." Interviews on 12/20/17 at 10:40 am with the Special Care Unit (SCU) Coordinator and the SCU Senior Coordinator revealed they were both unaware Resident #2 had the physician's order for a bed alarm, chair alarm and hipsters. Interview on 12/20/17 at 11:04 am with Resident #2's responsible party revealed: -She visited the facility 1 to 2 times weekly. -She was aware of Resident #2's falls. -The falls usually occurred when he was alone in his room. -She had never observed a bed alarm or chair alarm on Resident #2.	D 276		

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D 276	Continued From page 33 Telephone interview on 12/20/17 at 2:16 pm with the facility's contracted pharmacy revealed: -The facility faxed new physicians' orders to the pharmacy. -The pharmacy was responsible for filling the orders and entering them into the eMAR. -The MAs would be able to see the orders on the eMAR as soon as they were entered. -The pharmacy had not received the order for Resident #2's chair alarm, bed alarm and hipsters. Interview on 12/20/17 at 10:15 am with the Regional Director of Operations revealed: -She was serving as Interim Executive Director at this facility. -She was unaware Resident #2 had the order for a bed alarm, chair alarm and hipsters. -The Resident Care Director (RCD) was responsible for reviewing all physician's orders received and scanning the orders to the pharmacy. -If an order for chair alarms or bed alarms was received, the RCD was responsible for conducting a care conference with the family and staff coordinators and then adding the information to the resident's service plan so all staff would be aware. -The former RCD, employed when the physician's order was received, failed to perform these steps so the order for the chair alarm, bed alarm and hipsters was never implemented. Interview on 12/20/17 at 2:06 pm with the Registered Nurse (RN) from Resident #2's physician's office revealed: -Resident #2's physician had ordered a bed alarm, chair alarm and hipsters on 10/23/17 after the facility had reported the resident had an increase in falls.	D 276		

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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D 276	Continued From page 34 -The physician was unaware the facility had not implemented her orders for the alarms and hipsters. -Resident #2 was at risk for future falls, injuries and fractures if not wearing the alarms and hipsters. Refer to interview on 12/20/17 at 2:40 pm with the Regional RN. B. Resident #1's current FL-2, dated 7/11/17, revealed: -Diagnoses of Alzheimer's Disease, anxiety, hypertension, bladder cancer, melanoma, peptic ulcer, vertigo, varicose veins. -The recommended level of care for Resident #1 was special care unit. Interview on 12/20/17 at 12:45 pm with the Responsible Party for Resident #1 revealed: -Resident #1 had a new order earlier this month for compression stockings, which she was supposed to provide for the facility, but she had not yet had a chance to pick the compression stockings up and bring them to the facility. -She had told the facility that she would provide the compression stockings for Resident #1. -She had observed on the eMAR last week that staff had been documenting that they had been putting the compression stockings on and taking them off every day since they had received the order. She had not mentioned this to any staff member. Review of Resident #1's record revealed a signed physician's order, dated 12/5/17, which read: "compression stockings every day monitor." Review of Resident #1's Care Plan, dated	D 276		

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D 276	Continued From page 35 10/2/17, documented that she required minimal assistance dressing herself. Review of Resident #1's Licensed Health Professional Support (LHPS) Review, dated 9/14/17, reflected: -No task related to applying or removing TED hose. -An additional LHPS review, dated 12/19/17, was added to the chart during the investigation, which included applying and removing compression stockings daily. Review of Resident #1's electronic Medication Administration Record (eMAR) for December 2017 revealed: -Compression hose were added to the MAR on 12/5/17. -Compression hose were to be worn daily - on at 8am, removed at 8pm. -Compression hose were documented as being applied in the morning and removed in the evening each day from 12/6/17 - 12/17/17. -12/18/17 was documented that with the symbol "/" which reflects a "missed dose." There was no further documentation on the eMAR. Based on record review and observation of Resident #1 on 12/20/17, it was determined the resident was not interviewable. Observation of Resident #1 on 12/20/17 at 4:00 pm revealed she was not wearing compression stockings. Observation of Resident #1 on 12/22/17 at 1:00 pm revealed she was not wearing compression stockings. Confidential interview with Personal Care Aide	D 276			

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D 276	Continued From page 36 (PCA) revealed: -She had worked in the facility for several months and usually worked 1st shift. -She had been assigned many times to assist Resident #1, and had never assisted her in putting compression stockings on, or taking them off. -She was not aware that Resident #1 was supposed to wear compression stockings. Confidential interview with Medication Aide (MA) revealed: -She had never seen Resident #1 with compression stockings on. -She had signed off that the compression stockings were applied today. She was not aware that the resident did not have the stockings on. -She would sign off tasks in the eMAR system for the PCAs because they did not all have access to that system. Confidential interview with another MA revealed: -She was not aware that Resident #1 was supposed to wear compression stockings. -Resident #1 would change clothes multiple times a day, so if she had stockings on, she would likely take them off. Interview on 12/20/17 at 2:40 pm with the Regional Registered Nurse (RN) revealed: -The night shift MAs were responsible for ensuring TED hose had been applied and then documenting it on the eMAR. -The evening shift MAs were responsible for ensuring TED hose had been removed and then documenting it on the eMAR. -If TED hose could not be located for a resident, it was the MAs responsibility to either reorder them or notify the RCD so they could reorder them.	D 276		

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D 276	Continued From page 37 Refer to interview on 12/20/17 at 2:40 pm with the Regional RN. Interview on 12/20/17 at 2:40 pm with the Regional RN revealed: -She had been employed with this company since October 2015. -The facility's RCD position was currently open. -Another Regional RN had been filling in for the RCD two days per week, but was currently on vacation. -She was filling in at this facility due to the other Regional RN being on vacation. -When a new physician's order was received by the facility, the RCD or MA was responsible for faxing the order to the pharmacy and placing the original in the "new order box" in the RCD's office. -The RCD was responsible for completing a 48 hour verification to ensure the order had been transcribed to the eMAR. The facility failed to assure implementation of orders regarding a bed alarm, a chair alarm, hipsters, and anti-thrombotic hose (TED) for Resident #2 who continued to have falls and swollen legs; and compression hose for Resident #1 who continued to have falls and swollen legs, and compression hose for Resident #1. The facility's failure to implement physician's orders was detrimental to the safety and welfare of the residents which constitutes a Type B Violation. The facility provided a Plan of Protection on 12/20/17 as follows: -Immediately, staff will be trained on applying anti-thrombotic hose, and completing all treatments as prescribed. -Staff will be trained to assure orders and treatments are documented. -The Garden Place Coordinator (Special Care	D 276		

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D 276	Continued From page 38 Unit Coordinator) and or designee is to conduct random audits to ensure treatments are completed, including application of anti-thrombotic hose, as prescribed. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 5, 2018.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure all food and beverage being stored and served by the facility was protected from contamination. The findings are: Observation on 12/19/17 at 10:35 am of the dry storage area revealed: -Multiple out of date items were found in dry storage, including pancake syrup, flavored dessert syrups, dry baking mixes, granola, and baking powder. -There was an opened box of white icing mix, not labeled or dated when opened, that expired on 2/24/16. -Cereal was in unsealed plastic bags and not labeled or dated. -Pasta was in unsealed plastic bags and not	D 283	A review of all foods in the kitchen with expiration dates was completed during the survey. All expired items were immediately removed and the Dining Services Director (DSD) will review items on a daily bases and in the absence of the DSD, the ED and/ or designee will review to ensure all items approaching expiration are removed in a timely manner but not later than the noted expiration date.	22-Feb-18 and ongoing

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D 283	Continued From page 39 labeled or dated. -Rice was stored in an unsealed plastic bag, open to air, inside an open cardboard box, with a plastic drinking cup stuck into the rice. -There was a large container of salsa, three quarters empty, on a shelf. The container was clearly marked "promptly refrigerate after opening." There was no open date or label on the container. -There was an open 3 quart container of Apple Punch juice stored on the shelf. It was 1 quarter full of a hazy, reddish brown liquid. It was marked "refrigerate after opening." There was no open date or label on the container. -An opened container of Teriyaki sauce marked "refrigerate after opening," was stored on the shelf. There was no open date or label on the container. -An opened container of barbeque sauce marked "refrigerate after opening," was stored on the shelf. There was no open date or label on the container. Interview on 12/19/17 at 10:40 am with the Dietary Manager revealed: -She regularly checked expiration dates and disposed of out of date items. -She "tried to look through the pantry every two weeks or so." -She did not know why there were so many expired items in dry storage. -She did not know salsa, barbeque sauce, or teriyaki sauce had to be refrigerated. -She did not know why the juice was not refrigerated. -She did not know when the juice was last used, but thought it was opened the day before for an activity. Observation on 12/19/17 at 10:50 am of the walk	D 283		

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D 283	Continued From page 40 in refrigeration unit revealed: -A box of moldy cucumbers stored on a shelf with other produce. -A box of red bell peppers with two peppers cut in half and stored open to air in the box with other peppers. Several peppers were wilted. -An opened plastic bag of lettuce heads. The lettuce was starting to brown and the bag was not labeled or dated. Observation on 12/19/17 at 11:19 am of the walk in freezer unit revealed: -A tray of 5 ice cream and sherbet servings in bowls sitting atop several stacked cardboard boxes. The ice cream and sherbet was open to air and appeared to have "freezer burn." There was no label or date on the bowls or the tray. -An opened bag of hot dog buns on a shelf, not labeled or dated. Review of the Food Establishment Inspection Report dated 12/06/17 revealed: -A kitchen sanitation grade of 95. -Points deducted for "food in good condition, safe and unadulterated," for a bag of spoiled greens in the walk in refrigerator. -This was marked as a repeat violation. Interview on 12/20/17 at 11:25 am with the Dietary Manager revealed: -She received fresh produce once a week. -When she received the new produce boxes, she discarded the old boxes. -She therefore rotated produce items each week. -She kept opened perishable items for five days before discarding. -She did not know the cucumbers were molded. -She did not know why the red bell pepper halves were unwrapped in the box with other peppers. -She did not know why the ice cream servings	D 283		

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D 283	Continued From page 41 were exposed to open air on a tray in the freezer. She was unsure when they were prepared. Interview on 12/21/17 at 11:20 am with the Regional Director of Operations revealed: -She was serving as Interim Executive Director at this facility. -She was not aware of expired or contaminated food in the kitchen. -The dietary staff knew how to store food properly. -The facility had a policy regarding the labeling and storage of "leftovers." -She had not reviewed the latest kitchen sanitation inspection report. -Her expectation was that staff would dispose of any "old or moldy" food promptly. Review of the facility's policy titled "Leftovers" revealed: -Leftovers were to be used as soon as possible and not greater than 5 days after production unless frozen. -If frozen, food was to be properly packaged to prevent freezer burn and labeled with the date of production. -All items were to be covered, labeled, dated and stored properly.	D 283		
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	D 358	Immediate training of Medication Technicians (MTs) and Supervisors in Charge (SIC) was completed by the RCD and Director of Clinical Services (DOCS) during the survey, reinforcing the requirement that medications must be available and	22- Feb-18 and ongoing

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D 358	Continued From page 42 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 7 sampled residents regarding a resident (Resident #5) ordered a medication for osteoporosis. Review of Resident #5's previous FL-2 dated 08/16/17 revealed no medications were listed on the FL2. Review of Resident #5's FL-2 Verification Form dated 08/29/17 revealed an order for Alendronate Sodium (Fosamax) 70 mg, 1 tablet once weekly. Review of Resident #5's current FL2 dated 12/20/17 revealed: -Diagnoses of hypertension, cerebrovascular accident in August 2014, spinal stenosis, osteoporosis, hyperlipidemia, right knee osteoarthritis, peripheral venous insufficiency, carotid artery occlusion in December 2011. -An order for Fosamax 70 mg, 1 tablet once a week with 8 oz water, 30 minutes prior to other medications or food. Don't lie down. Review of Resident #5's September 2017 electronic Medication Administration Record (eMAR) revealed: -An entry for Fosamax 70 mg, 1 tab once weekly with 8 oz of water. -Fosamax was documented as administered on 09/13/17. -Fosamax was not documented as administered	D 358	administered to all residents as prescribed by the primary care physician. Additionally, MTs were re-educated on proper shift to shift eMAR review to ensure any medications that are not documented are discussed and resolved prior to the completion of shift change. An independent audit was conducted by Kerr Pharmacy on Tuesday, January 30 on all medication carts to ensure medications were available, discontinued medications were removed from the carts and there were no expired medications on the carts. The RCD and/or designee will monitor daily for instances of missing or incompleated documentation and investigate to resolution immediately when identified. Medication carts will be audited weekly against the resident's e-MAR to ensure medications are available and ordered in advance to mitigate instances of medications not available. This will be reviewed weekly by the Regional Nurse, DOCS and/or Corporate Director of Clinical Services to ensure ongoing compliance.	

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D 358	Continued From page 43 on 09/06/17, 09/20/17, and 09/27/17. -There was no reason documented for the missed doses. Review of Resident #5's October 2017 eMAR revealed: -An entry for Fosamax 70 mg, 1 tab once weekly with 8 oz of water. -Fosamax was documented as administered on 10/11/17. -Fosamax was not documented as administered on 10/04/17, 10/18/17, and 10/25/17. -There was no reason documented for the missed doses. Review of Resident #5's November 2017 eMAR revealed: -An entry for Fosamax 70 mg, 1 tab once weekly with 8 oz of water. -Fosamax was documented as administered on 11/01/17, 11/15/17, and 11/29/17. -Fosamax was not documented as administered on 11/08/17, and 11/22/17. -There was documentation in the notes section "Resident refused" on 11/22/17. Review of Resident #5's December 2017 Medication eMAR revealed: -An order for Fosamax 70 mg, 1 tab once weekly with 8 oz of water. -Fosamax was documented as not administered on 12/06/17, 12/13/17, and 12/20/17. -There was documentation in the notes section "Resident refused," for all three dates. Review of medications on hand for administration for Resident #5 on 12/20/17 revealed: -A box of Fosamax filled on 6/15/17 by a private pharmacy before Resident #5 was admitted to the facility with 3 of 4 tablets remaining.	D 358		

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D 358	Continued From page 44 -A box of Fosamax filled on 8/31/17 by the facility's contracted pharmacy with 2 of 4 tablets remaining. -A box of Fosamax filled on 11/15/17 by the facility's contracted pharmacy with 4 of 4 tablets remaining. -A box of Fosamax filled on 12/06/17 by the facility's contracted pharmacy with 4 of 4 tablets remaining. Telephone interview on 12/20/17 at 09:29 am, with a representative for the contracted pharmacy provider revealed: -The pharmacy received an order for Fosamax along with resident's other medications when she arrived at the facility on 8/29/17. -They filled the Fosamax order on 8/31/17, 11/15/17, and 12/06/17. -Fosamax came in a box of 4 tablets for a 30 day supply and was to be administered once a week for osteoporosis. -Fosamax was usually given early in the morning because it could not be given with other medications or food, and the resident had to remain upright for 30 minutes after taking the medicine. -The medication should have been given a total of 16 times from 09/01/17 to 12/20/17. Observation on 12/20/17 at 10:00 am of Resident #5's Fosamax boxes on hand revealed: -There were 13 tablets total available on hand, including the box brought from home containing 3 tablets. -According to the dispense dates, quantity dispensed (12) and amounts documented as administered (5 tablets from 09/01/17 to 12/20/17), there should have been enough Fosamax 70 mg tablets to have been administered between 09/01/17 to 12/20/17.	D 358			

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D 358	Continued From page 45 -If administered correctly according to the eMARs, there should have been 2 capsules on hand from the contracted pharmacy and available to be administered, but there were 10 of the 12 tablets of Fosamax 70 mg on hand and available for administration. Interview on 12/20/17 at 10:10 am with a first shift Medication Aide (MA) revealed: -Fosamax was listed on the eMAR for administration at 6:30 am, which was third shift. -She was not sure why the medication had not been given. -Resident #5 had never refused medications when she administered them. Second interview on 12/20/17 at 2:40 pm with the first shift MA revealed: -The Fosamax was missed that morning and then marked as refused. -The resident was up from bed at 6:00 am that morning. -Third shift staff gave Resident #5 tylenol for pain at 6:19 am but did not give the Fosamax. -She did not know why the Fosamax was not given. -The Resident Care Director (RCD) or Resident Care Coordinator (RCC) was responsible for auditing the medication carts. -She did not know how often they audited the carts. -She did not know why there was so much Fosamax on hand for Resident #5. Attempted interviews on 12/20/17, 12/21/17, and 12/22/17 with a third shift MA were unsuccessful. Telephone interview on 12/21/17 at 10:30 am with a nurse from Resident #5's primary care provider (PCP) revealed:	D 358		

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D 358	Continued From page 46 -The PCP was not aware Resident #5 was not receiving the Fosamax as ordered. -No one from the facility had contacted his office to inform them the Fosamax was not given. -Fosamax was prescribed to Resident #5 to help prevent osteoporosis. -His expectation was the medication would be given as ordered. -If the resident refused, he expected the facility to notify his office after 2 refusals. -Not taking the medication could lead to increased bone fragility and risk of broken bones if the resident was to fall or get injured. Interview on 12/20/17 at 10:30 am with Resident #5 revealed: -She remembered taking Fosamax at home, once a week, first thing in the morning before breakfast. -She did not recall being given Fosamax at all since moving to the facility. -She never refused medications. -She usually got up every morning around 6 am, but did not receive any medications until 7:30 am or later. -Occasionally she would get Tylenol early in the morning for pain. Interview on 12/20/17 at 10:49 am with Resident #5's family member revealed: -He was not aware the resident was not receiving her Fosamax weekly. -Resident #5 took the Fosamax weekly while living at home and did not miss doses. -The resident did not refuse medication. -He had not been informed by the facility that Resident #5 was missing any medication doses. Interview on 12/21/17 at 9:40 am with the Director of Clinical Services revealed:	D 358		

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D 358	Continued From page 47 -MA staff were expected to check for missed medications each shift change and make corrections. -The RCD was supposed to review the eMARs every day to check for errors or "holes." -The Regional Nurse would audit MARs periodically. -If a pattern of refusal was noted, usually more than 3 refusals in a row, the provider should be notified. -If a medication was marked as "Not Administered" several times in a row, the provider should be notified. -The policy did not specify that a certain number of missed or refused doses had to be noted before notifying the provider. -She did not know why the provider had not been notified regarding Resident #5's Fosamax.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure staff	D 366	Immediate training of all Medication Technicians (MTs) and Supervisors in Charge (SIC) was completed by the RCD and Director of Clinical Services (DOCS) during the survey.	5-Feb-18 and ongoing

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D 366	Continued From page 48 documented the administration of medications immediately following the administration and observation of the resident actually taking the medications for 1 of 7 sampled residents (Resident #1) with medications found in the resident's room including cardiac and blood pressure medications which resulted in hospitalization. The findings are: Review of Resident #1's current FL-2 dated 7/11/17 revealed: -Diagnoses of Alzheimer's disease, anxiety, hypertension, bladder cancer, melanoma, peptic ulcer, vertigo, and varicose veins. -The recommended level of care for Resident #1 was special care unit. Interview on 12/20/17 at 12:45 pm with Resident #1's Responsible Party revealed: -In November of 2016 she found 4 or 5 pills in Resident #1's nightstand drawers. She recalled staff conducted a "thorough check" of Resident #1's room after this incident. -In April 2017 she found a pill wrapped up in a napkin, and pills in other places throughout her room, including an altoid tin in Resident #1's purse that contained several pills (approximately 12 pills in the resident's room at that time). -On 12/6/17, she discovered 6 pills under Resident #1's pillow, and one pill on the floor. She gave the pills to the office manager, who took them to the Medication Aide. The medication aide told her several of the pills were Resident #1's heart medications. -On 12/16/17, she received a call from the facility that Resident #1 was not feeling well. She went directly to the facility, and found Resident #1 sitting in the "quiet room" with a staff member	D 366	This training included the 6 rights of medication administration with an additional focus on ensuring residents have swallowed medications Additional trainings have occurred and will continue to be conducted to ensure ongoing compliance. The community also completed an audit of all resident rooms to ensure there were no unsecured medications. The RCD will also conduct Medication Pass Observations with MTs and SICs to monitor proper medication administration processes to include ensure residents have swallowed scheduled medications, prior to documentation.	

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D 366	Continued From page 49 present. Resident #1 was very hot and pale. She took the resident's sweater off, and observed a ziplock bag hanging out of her pants pocket that contained 4 pills. The medication aide that was present took the pills. -Each time she had found pills, she had brought it to the attention of management, and each time she was given the same response of "this is an isolated event - the medication aide is new, and we will provide retraining to ensure they observe Resident #1 swallows the medications." -She never observed any pills she had found to look as though they had been in Resident #1's mouth. Continued interview on 12/20/17 at 12:45 pm with Resident #1's Responsible Party revealed: -Resident #1 had been treated in a local Emergency Department on multiple occasions over the past year for not feeling well or feeling faint. The hospital staff, as well as her primary care physician, had often questioned if she had been getting her medications correctly. -Resident #1 went to the Emergency Department on 10/16/17 and was admitted for a few days. The facility provided Resident #1's Medication Administration Record for October 2017 to the responsible party. She recalled there appeared to be a lot of missed medications documented around the time of admission to the hospital. -Facility staff had told her that they made three attempts to administer medications when residents refused them. She had requested on multiple occasions that after Resident #1 refused the 2nd time, that the facility notify her so that she could try to intervene to assure that Resident #1 took her medications. She had never been contacted under these circumstances. Review of Resident #1's local hospital Emergency	D 366		

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D 366	Continued From page 50 Department (ED) Visit Summary dated 10/14/17 - 10/16/17 revealed: -Resident #1 was admitted with a diagnosis of "atrial fibrillation with rapid ventricular response." -A medication change was documented reflecting Metoprolol 25mg (used to treat angina and hypertension), had been stopped, and Metoprolol 50mg 24-hour release had been started. Review of Resident #1's care notes revealed: -On 10/14/17 it was documented that "resident was getting admitted to hospital. Resident blood pressure was high ...heart rate was very high. Hospital decided to admit resident due to a high level of BP at risk for stroke." -On 12/3/17 it was documented that "resident was feeling faint. Upon taking her BP [supervisor] sent her to ER. She returned at 2100. Follow up with doctor in 2 days. No new orders." There was no documentation of the blood pressure reading. -On 12/5/17, it was documented that "there was [sic] pills found in (redacted - resident's name) that she did not take. These were pills that she needs to take daily. "No exceptions" when passing meds we need to make sure that all meds have been swallowed. Do not leave the resident until you have made sure they have digested all of them. These pills included her heart medicine that she absolutely have to take." -On 12/6/17 the regional nurse documented that a home health "referral had been made for medication management and to follow for recent issues and med complaints." Review of Resident #1's care notes revealed: -On 12/16/17 at 12:00 pm it was documented that the "resident complained of feeling dizzy [supervisor] took vitals and resident still complained of being dizzy and very hot. SIC observed resident had on two turtle neck sweaters. After removing one sweater resident	D 366		

Division of Health Service Regulation		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		A. BUILDING: _____		B. WING: _____		C 12/22/2017	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
CARILLON ASSISTED LIVING OF HUNTERSVILLE		250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078					
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D 366	Continued From page 51 began to feel better. BP 146/86, temp 97.7, pulse 70, resp 38. Observed resident at 1pm she's feeling better." Review of Resident #1's Accident/Incident Report dated 12/16/17 revealed "resident's daughter pulled a little bag out of (redacted - resident's name) pocket and it had 4 pills in it that she had not taken. Med techs need to stay with the resident to make sure all medications have been taken. Do not leave any medications." Confidential interview with 4 Medication Aides (MA) revealed: -They had never had a problem administering medications to Resident #1. - They would always check Resident #1's mouth to assure she had swallowed her medications. - They had all been instructed to observe Resident #1 to assure she had swallowed the medications. - 3 of the 4 medication aides were aware pills had been found in Resident #1's room. Review of the facility Medication Administration Policy revealed: -The policy did not include any process for observing residents take medications. -The policy did not include any process for what to do when medications were found in a resident's possession. -The policy stated that "the resident has the right to refuse medications; however, the Med Tech should strongly encourage the resident to take all medications as prescribed by their physician. In the event the Med Tech is unsuccessful in convincing the resident to take the medication as prescribed, the not administered reason documented in the e-mar is resident refusal the Med Tech should notify the physician and	D 366					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/22/2017
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
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D 366	Continued From page 52 Resident Care Director if a "pattern" of refusal is noted In the event the resident is in the secured unit, the Med Tech should seek the assistance of their supervisor to re-approach the resident for successful administration." 1. Review of Resident #1's current FL-2, dated 7/11/17, revealed orders for 15 medications including Eliquis 5mg, (used to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation) twice a day. Review of Resident #1's current physician's orders, dated 10/26/17, revealed 18 medications, including an order for Eliquis 2.5mg, administered by mouth, twice a day. Review of Resident #1's October 2017 electronic Medication Administration Records (eMAR) revealed: -Eliquis 2.5 mg was transcribed and scheduled for administration at 8:00 am and 8:00 pm daily. -Eliquis 2.5mg was documented as "not administered" at 8:00 am on 10/12/17 (with a reason of "did not administer"), at 8:00 am on 10/13/17 (with a reason of "resident refused"), at 8:00 pm on 10/14/17 to 8:00 am on 10/16/17 (hospital), at 8:00 am on 10/18/17 (with a reason of "did not administer"), and at 8:00 am on 10/20/17 (with a reason of "did not administer.") Refer to review of Resident #1's local hospital Emergency Department Visit Summary dated 12/3/17. Refer to interview on 12/21/17 at 9:40 am with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:15 pm with the Regional Director of Operations.	D 366			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER
CARILLON ASSISTED LIVING OF HUNTERSVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
**250 COMMERCE CENTER DRIVE
HUNTERSVILLE, NC 28078**

(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 366	Continued From page 53 2. Review of Resident #1's current FL-2, dated 7/11/17, revealed orders for 15 medications including Losartan 50mg, (used to treat high blood pressure and reduce the risk of stroke in certain people with heart disease) once a day. Review of Resident #1's current physician's orders, dated 10/26/17, revealed 18 medications, including an order for Losartan 50mg, once a day. Review of Resident #1's October 2017 electronic eMAR revealed: -Losartan 50 mg was transcribed and scheduled for administration at 8:00 am daily. -Losartan 50 mg was documented for not administered at 8:00 am on 10/12/17 (with a reason of "did not administer"), at 8:00 am on 10/13/17 (with a reason of "resident refused"), at 8:00 am on 10/14/17 through 10/16/17 (hospital), at 8:00 am on 10/18/17 ("did not administer"), and at 8:00 am on 10/20/17 (with a reason of "did not administer.") Telephone interview on 12/21/17 at 1:00 pm with the facility's Contract Pharmacy revealed they had filled Losartan 50mg on 9/11/17, 10/20/17, 11/12/17, and 12/05/17, with a quantity of 30 each time. Refer to review of Resident #1's local hospital Emergency Department Visit Summary dated 12/3/17. Refer to interview on 12/21/17 at 9:40 am with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:15 pm with the Regional Director of Operations.	D 366		

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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078
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D 366	Continued From page 54 3. Review of Resident #1's current physician's orders, dated 10/26/17, revealed 18 medications including an order for Metoprolol 50mg, once a day in the morning. Review of Resident #1's October 2017 electronic eMAR revealed: -Metoprolol 25 mg was transcribed and scheduled for administration at 8:00 am, and 8:00 pm daily from 10/01/17 until 10/16/17. -Metoprolol 25mg was documented for not administered at 8:00 am (with a documented reason of "did not administer") and at 8:00 pm (with reason "ms") on 10/12/17, and at 8:00 am (with a documented reason of "resident refused.") and 8:00 pm (resident out of facility) on 10/13/17, and at 8:00 pm on 10/14/17 through 8:00 pm on 10/16/17 (hospital) The MAR reflected that the Metoprolol 25mg was discontinued on 10/16/17. -Metoprolol 50mg was transcribed and scheduled for administration at 8:00 am from 10/16/17 to 10/31/17. -Metoprolol 50mg was documented for not administered at 8:00 am on 10/18/17 (reason "did not administer") and at 8:00 am on 10/20/17 (reason of "did not administer"). Telephone interview on 12/21/17 at 1:00 pm with the facility's Contract Pharmacy revealed: -The pharmacy had dispensed a refill for Metoprolol 25mg on 9/7/17. There was a dosage increase to 50mg on 10/16/17, at which time the order was filled. -Metoprolol 50mg was also filled on 11/22/17 and 12/20/17, with a quantity of 30 each time. Observations of Resident #1's room on 12/19/17 at 12:30 pm, 12/20/17 at 3:45 pm, and 12/22/17 at 12:00 pm revealed no medications were observed in the resident's room.	D 366		

Division of Health Service Regulation		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	A. BUILDING: _____ B. WING: _____	C 12/22/2017
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D 366	Continued From page 55 Refer to review of Resident #1's local hospital Emergency Department Visit Summary dated 12/3/17. Refer to interview on 12/21/17 at 9:40 am with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:15pm with the Regional Director of Operations. Review of Resident #1's local hospital Emergency Department Visit Summary dated 12/3/17 revealed: - Resident #1 was seen in the emergency department as a result of "near syncope" with diagnoses of "near syncope, chronic atrial fibrillation, long-term use of anticoagulant, and uncontrolled hypertension." Interview on 12/21/17 at 9:40 am with the Director of Clinical Services revealed: -MA staff were expected to check for missed medications each shift change and make corrections. -The RCD was supposed to review the eMAR every day to check for errors or "holes." -The current RCD was on vacation that week. -The Regional nurse would audit MARS periodically. -If a pattern of refusal was noted, usually more than 3 refusals in a row, the provider would be notified. -If a medication was marked as "Not Administered" several times in a row, the provider would be notified. Interview on 12/22/17 at 12:15pm with the Regional Director of Operations revealed: -She was serving as Interim Executive Director at	D 366		

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D 366	Continued From page 56 this facility. -When the facility was made aware earlier this month that pills had been found in Resident #1's bed and on the floor, they had quickly put several measures into place to prevent it from happening again, including increased room checks, an in-service on medication administration was provided to staff on 12/11/17, and increased supervision and observations of medication administration. -She was made aware that more pills were found in Resident #1's pocket on Saturday (12/16/17). -After the pills were found Saturday (12/16/17), she had staff conduct an audit that day of all resident rooms, and no other pills were found. More audits of all rooms would be conducted on a routine basis to monitor for medications. -The facility had provided additional training for medication staff last night on medication administration, and additional training was scheduled for today. The facility failed to assure staff documented the administration of medications immediately following the administration and observation of the resident actually taking the medications for 1 of 7 sampled residents regarding a resident (Resident #1) with medications found in the resident's room including cardiac and blood pressure medications which resulted in hospitalization. The facility's failure to observe Resident #1 taking medications before documenting medication administration was detrimental to health, safety, and welfare of the resident and constitutes a Type B Violation. Review of the facility's Plan of Protection dated 12/20/17 revealed: -Immediate training on all medication staff on medication administration, medication	D 366		

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NAME OF PROVIDER OR SUPPLIER
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D 366	Continued From page 57 administration records are documented timely, and medications are observed taken, including swallowing. -Medication staff will be trained on administering medications as ordered. -Initial training will be by the Resident Care Director (RCD), Regional Director of Operations, and/or designee. The RCD will be responsible for ongoing training and monitoring. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 5, 2018.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication	D 367	Immediate training of all MTs and SICs was completed by the RCD and DOCS during the survey. This training included proper narcotic management with a focus around proper and immediate documentation on both the eMAR and the declining balance sheet. This will be monitored weekly on a random basis by the RCD and/or Regional Nurse (RN) to ensure ongoing compliance. Additionally, the RCD will also conduct Medication Pass Observations with every MT and SIC to monitor proper documentation with all medications administered, to include narcotics.	22- Feb-18 and ongoing

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D 367	Continued From page 58 administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 4 of 7 sampled residents (#1, #7, #8, and #9) related to documenting administration of lorazepam and oxycodone. The findings are: Review of the facility Narcotic Control Safety Measures Policy revealed: -"Each time a dose is administered, the Med Tech must document the dose on the relevant count sheet along with the remaining inventory of the narcotic left in stock". -"All Medication Technicians must ensure a shift to shift count occurs wherein the total count and content of each narcotic container is verified. Both the exiting Med tech and the arriving Med tech must sign the narcotic inventory control sheet verifying the count is correct". -"Should any variances be identified during the narcotic count, both team members are to notify their immediate supervisor at the time the variance is identified. Failure to notify your supervisor at the time a variance is identified will result in disciplinary action". A. Review of Resident #8's current FL-2 dated 2/15/17 revealed -Diagnoses included Alzheimer's dementia, mood disorder, and anxiety. -There was an order for Ativan 0.5 mg (used to treat anxiety) one tablet 3 times a day. (Lorazepam is generic for Ativan). -There was an order for Ativan 0.5mg one tablet 3	D 367		

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D 367	Continued From page 59 times daily as needed for anxiety. Review of Resident #8's record revealed signed physician's orders dated 05/23/17 as follows: -There was an order for lorazepam 0.5 mg (used to treat anxiety) one tablet 3 times a day. -There was an order for lorazepam 0.5mg one tablet 3 times daily as needed for anxiety. Review of Resident #8's record revealed a subsequent physician's order dated 5/25/17 to discontinue lorazepam 0.5 mg as needed. Review of Resident #8's electronic Medication Administration Record (eMAR) for November 2017 revealed: -Lorazepam 0.5 mg, one tablet 3 times a day, hold for sedation, was transcribed and documented for administration 90 of 90 opportunities from 11/01/17 to 11/30/17 as scheduled. Review of Resident #8's CSL (Controlled Substance Log) for lorazepam 0.5 mg available for review compared to the November 2017 eMAR revealed there were 12 doses documented as administered on the eMAR but not documented as administered on Resident #8's CSLs. Examples of the dates and times documented on the November eMAR but not accounted for on the available CSL were as follows: -On 11/11/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 11/12/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 11/13/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 11/19/17 at 2:00 pm- administration	D 367		

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D 367	Continued From page 60 documented on eMAR- not located on CSL. -On 11/23/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 11/27/17 at 2:00 pm- administration documented on eMAR- not located on CSL. Review of Resident #8's eMAR for December 2017 revealed: -Lorazepam 0.5 mg, one tablet 3 times a day, hold for sedation, was transcribed and scheduled for administration at 8:00 am, 2:00 pm and 8:00 pm daily, and was documented as administered 60 of 60 opportunities from 12/01/17 to 12/20/17 as scheduled. Review of Resident #8's CSL for lorazepam 0.5 mg available for review compared to the December 2017 eMAR revealed there were 10 doses documented as administered on the eMAR but not documented as administered on Resident #8's CSLs. Examples of the dates and times documented on the December 2017 eMAR but not accounted for on the available CSL were as follows: -On 12/02/17 at 8:00 am and at 2:00 pm- administration documented on eMAR- not located on CSL. -On 12/03/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 12/07/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 12/13/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 12/16/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 12/17/17 at 2:00 pm- administration documented on eMAR- not located on CSL. Review of Resident #8's CSL for lorazepam 0.5	D 367		

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D 367	Continued From page 61 mg, administered one tablet 3 times a day, revealed: -On 12/12/17, a total of 4 tablets were documented as administered on the CSL; one tablet at 9:20 (no am or pm documented) on the CSL for 30 of 90 tablets dispensed on 11/10/17, and one tablet at 9:20 am, at 1:50 pm, and at 7:10 pm on the CSL for 60 of 90 lorazepam 0.5 mg dispensed on 10/17/17. -It could not be determined if Resident #8 received 3 doses or 4 doses of lorazepam 0.5mg. Based on record review and observation of Resident #8 on 12/21/17, it was determined the resident was not interviewable. Attempted telephone interview on 12/22/17 at 11:15 am with Resident #8's Power of Attorney was unsuccessful. Refer to interview on 12/20/17 at 10:30 am with a Medication Aide/Supervisor (MAS). Refer to interview on 12/21/17 at 12:30 pm with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:32 pm with the Director of Clinical Services. B. Review of Resident #9's current FL-2 dated 9/13/17 revealed: -Diagnoses included Alzheimer's dementia, congestive heart failure, and skin cancer. -The resident's level of care was special care unit. 1. Review of Resident #9's current FL-2 dated 09/13/17 and signed physician's orders dated 11/13/17 revealed: -There was an order for lorazepam 1 mg (used to	D 367		

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D 367	Continued From page 62 treat anxiety) one tablet before supper and before bedtime. -There was an order for lorazepam 1 mg one tablet once daily as needed for agitation. Telephone interview on 12/21/17 at 4:30 pm with a contract pharmacy representative regarding lorazepam 1 mg dispensed for Resident #9 revealed the pharmacy dispensed 60 lorazepam 1 mg on 10/20/17 (one bubble pack of 60 tablets). Review of Resident #9's medication on hand on 12/20/17 revealed a container of lorazepam 1 mg labeled for 60 tablet dispensed on 11/24/17 from a local pharmacy with 4 tablets remaining which matched the Controlled Substance log (CSL) maintained by the facility. Review of Resident #9's electronic Medication Administration Record (eMAR) for November 2017 revealed: -Lorazepam 1 mg, one tablet before supper and before bedtime, was transcribed and scheduled for administration at 4:30 pm and 8:00 pm. -Lorazepam 1 mg one tablet once daily as needed for agitation was listed and scheduled PRN (as needed). -Lorazepam 1 mg was documented as administered 51 of 60 scheduled opportunities from 11/01/17 to 11/30/17. -There were 5 doses of lorazepam 1 mg documented as administered PRN on the November eMAR and CSL. Review of Resident #9's CSL for lorazepam 1 mg available for review compared to the November 2017 eMAR revealed: -There were 7 scheduled doses documented not administered on the eMAR, and documented as	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER
CARILLON ASSISTED LIVING OF HUNTERSVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
**250 COMMERCE CENTER DRIVE
HUNTERSVILLE, NC 28078**

(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 367	Continued From page 63 not administered on Resident #9's CSL. -There were 2 scheduled doses, 8:00 pm on 11/24/17 and 8:00 pm on 11/29/17, documented as not administered on the November eMAR but documented (signed out) as administered on the resident's CSL. Review of Resident #9's eMAR for December 2017 revealed: -Lorazepam 1 mg, one tablet before supper and before bedtime, was transcribed and scheduled for administration at 4:30 pm and 8:00 pm. -Lorazepam 1 mg one tablet once daily as needed for agitation was listed and scheduled PRN (as needed). -Lorazepam 1 mg was documented for administration 40 of 40 scheduled opportunities from 12/01/17 to 12/20/17. -There were 5 doses of lorazepam 1 mg documented as administered PRN on the November eMAR and CSL. Review of Resident #9's CSL for lorazepam 1 mg available for review compared to the December 2017 eMAR revealed on 12/05/17 one dose of lorazepam 1 mg was documented administered on the CSL at 12:30 pm (PRN), but not documented on the December 2017 eMAR. Review of Resident #9's medication on hand on 12/20/17 revealed a container of lorazepam 1 mg labeled for 60 tablet dispensed on 11/24/17 from a local pharmacy with 4 tablets remaining which matched the CSL maintained by the facility. Based on record review and observation of Resident #9 on 12/21/17, it was determined the resident was not interviewable. Telephone interview on 12/22/17 at 1:15 pm with	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078
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(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 367	Continued From page 64 Resident #9's family member revealed: -She was aware Resident #9 was out of at least one medication for one day (11/23/17) while new orders was being received. -She was not aware of any behaviors or increased anxiety that the resident had experienced. Refer to interview on 12/20/17 at 10:30 am with a Medication Aide/Supervisor (MAS). Refer to interview on 12/21/17 at 12:30 pm with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:32 pm with the Director of Clinical Services. 2. Review of Resident #9's current FL-2 dated 09/13/17 and signed physician's orders dated 11/13/17 revealed: -There was an order for oxycodone 5 mg (used to treat pain) one tablet every 8 hours (scheduled). -There was an order for oxycodone 5 mg every 4 hours as needed for pain. Review of Resident #9's electronic Medication Administration Record (eMAR) for November 2017 revealed: -Oxycodone 5 mg one tablet every 8 hours was transcribed and scheduled at 6:00 am, 2:00 pm, and 10:00 pm. -Oxycodone 5 mg one tablet every 4 hours as needed for pain was transcribed and scheduled as needed. -Oxycodone 5 mg was documented for administration 44 of 51 scheduled opportunities from 11/13/17 to 11/30/17. -There were 4 PRN (as needed) doses documented as administered on the eMAR with corresponding documentation for administration	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
(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 367	Continued From page 65 on the CSL. Review of Resident #9's CSL for oxycodone 5 mg compared to the November 2017 eMAR revealed: -There were 7 scheduled doses documented not administered on the eMAR and not signed out on Resident #9's CSL. -There were 2 scheduled doses, 6:00 am and 2:00 pm on 11/28/17, documented as not administered on the November eMAR but documented (signed out) as administered on the resident's CSL. Telephone interview on 12/21/17 at 4:30 pm with a contract pharmacy representative regarding oxycodone 5 mg dispensed for Resident #9 revealed the pharmacy dispensed 90 oxycodone 5 mg on 10/24/17 and none since. Review of Resident #9's CSL (CSL for 90 tablets dispensed on 10/24/17 and 90 tablets on 11/24/17) revealed 79 oxycodone 5 mg tablets were documented as administered from 11/01/17 to 11/30/17 compared to 83 oxycodone 5 mg tablets documented as administered on Resident #9's November 2017 eMAR. Review of Resident #9's electronic Medication Administration Record (eMAR) for December 2017 revealed: -Oxycodone 5 mg one tablet every 8 hours was transcribed and scheduled at 6:00 am, 2:00 pm, and 10:00 pm. -Oxycodone 5 mg one tablet every 4 hours as needed for pain was transcribed and scheduled as needed. -Oxycodone 5 mg was documented for administration 52 of 55 scheduled opportunities from 12/1/17 to 12/20/17. -There were 11 PRN (as needed) doses	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078
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(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 367	Continued From page 66 documented as administered on the eMAR with corresponding documentation for administration on the CSL. Review of Resident #9's CSL for oxycodone 5 mg compared to the December 2017 eMAR revealed: -There were 3 scheduled doses, 10:00 pm on 12/7/17, 10:00 pm on 12/16/17, and 10:00 pm on 12/18/17, documented as not administered on the December eMAR, but documented (signed out) as administered on the resident's CSL. -There was one dose at 7:30 pm on 12/13/17 not documented as administered on the eMAR, but documented as administered on the CSL. Review of Resident #9's CSL (for 90 tablets dispensed on 11/24/17) revealed 63 oxycodone 5 mg tablets were documented as administered from 12/01/17 to 12/20/17 at 2:00 pm compared to 60 oxycodone 5 mg tablets documented as administered on Resident #9's December 2017 eMAR. Based on record review and observation of Resident #9 on 12/21/17, it was determined the resident was not interviewable. Review of Resident #9's medication on hand on 12/20/17 revealed a container of oxycodone 5 mg labeled for 90 tablet dispensed on 11/24/17 from a local pharmacy with 12 tablets remaining which matched the Controlled Substance log (CSL) maintained by the facility. Telephone interview on 12/22/17 at 1:15 pm with Resident #9's family member revealed: -She was aware Resident #9 was out of at least one medication for one day (11/23/17) while new orders was being received.	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
(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 367	Continued From page 67 -She was not aware of any behaviors or increased anxiety that the resident had experienced. -The facility was managing the resident's pain. Refer to interview on 12/20/17 at 10:30 am with a Medication Aide/Supervisor (MAS). Refer to interview on 12/21/17 at 12:30 pm with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:32 pm with the Director of Clinical Services. C. Resident #1's current FL-2, dated 7/11/17, revealed: -Diagnoses of Alzheimer's Disease, anxiety, hypertension, bladder cancer, melanoma, peptic ulcer, vertigo, varicose veins. -The recommended level of care for Resident #1 was special care unit. Resident #1's current physician's orders, dated 10/26/17, revealed the following medication orders: -Lorazepam 0.5mg, (used to treat anxiety) administered by mouth, once a day at 4:00 pm. -Lorazepam 0.5mg, by mouth, once a day as needed for anxiety. Review of Resident #1's electronic Medication Administration Record e(MAR) for November 2017 revealed lorazepam 0.5mg, daily at 4:00 pm, was documented as being administered on 11/6/17 and also on 11/13/17. Review of Resident #1's Controlled Substance Log (CSL) for lorazepam 0.5mg, administered daily at 4:00 pm, was not documented as administered on either 11/6/17 or 11/13/17.	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078
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(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 367	Continued From page 68 Review of Resident #1's eMAR for December 2017 revealed lorazepam 0.5mg, administered daily at 4:00 pm was documented as administered every day from 12/01/17 to 12/31/17. Review of Resident #1's CSL for lorazepam 0.5mg, administered daily at 4:00 pm revealed lorazepam 0.5mg was not documented as administered on 12/18/17, 12/19/17, or 12/20/17. Refer to interview on 12/20/17 at 10:30 am with a Medication Aide/Supervisor (MAS). Refer to interview on 12/21/17 at 12:30 pm with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:32 pm with the Director of Clinical Services. D. Resident #7's current FL-2 dated 2/28/17 revealed diagnoses of Parkinson's disease, benign prostatic hyperplasia, and history of colon cancer. Review of Resident #7's record revealed a current prescription, dated 9/12/17, for lorazepam 0.5mg, (used to treat anxiety), 4 times a day. Review of Resident #7's electronic Medication Administration Record (eMAR) for September 2017 revealed lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 9/27/17. Review of Resident #7's Controlled Substance Log (CSL) for lorazepam 0.5mg, administer 4 times daily, from 9/13/17 through 9/27/17	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
(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 367	Continued From page 69 revealed: -A medication aide (MA) documented as administered lorazepam 0.5mg, on 9/27/17 at 8:58 am, 3:32 pm, and 8:06 pm. -There was not a fourth dose documented as administered for 9/27/17. Review of Resident #7's eMAR for October 2017 revealed: - Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 10/01/17. - Lorazepam had been documented as administered at 8:00 am, 4:00 pm, and 8:00 pm on 10/09/17. - Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 10/10/17. Review of Resident #7's CSL for lorazepam 0.5mg, administer 4 times daily, from 9/28/17 through 10/13/17 revealed: -A MA documented as administered lorazepam 0.5mg on 10/01/17 at 11:41 am, 3:41 pm, and 7:15 pm. -There was not a fourth dose documented as administered for 10/01/17. -A MA documented as administered lorazepam 0.5 mg on 10/09/17 at 7:40 am and 8:00 pm. -There was not a third dose or fourth documented as administered for 10/09/17. - A MA documented as administered lorazepam 0.5 mg on 10/10/17 at 11:46 am, 2:00 pm, 3:25 pm, and 7:07 pm. -The administration times on 10/10/17 did not match the times given on the eMAR. Review of the CSL for lorazepam 0.5mg, administer 4 times daily, from 10/14/17 through 10/28/17 revealed no inaccuracies.	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
(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 367	Continued From page 70 Review of Resident #7's eMAR for November 2017 revealed: -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 11/05/17. -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 11/07/17. -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 11/17/17. -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 11/26/17. -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 11/29/17. -There was no fifth dose documented on the eMAR for 11/29/17. Review of the CSL for lorazepam 0.5mg, administer 4 times daily, from 10/29/17 through 11/14/17 revealed: -A MA documented as administered lorazepam 0.5mg on 11/05/17 at 10:00 am, 4:00 pm, and 7:00 pm. -There was not a fourth dose documented as administered for 11/05/17. -A MA documented as administered lorazepam 0.5mg on 11/07/17 at 11:09 am, 3:55 pm, and 7:36 pm. -There was not a fourth dose documented as administered for 11/07/17. Review of the CSL for lorazepam 0.5mg, administer 4 times daily, from 11/14/17 through 11/29/17 revealed: -A MA documented as administered lorazepam 0.5mg on 11/17/17 at 2:00 pm, 4:32 pm, and 7:04	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078
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(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 367	Continued From page 71 pm. -There was not a fourth dose documented as administered for 11/17/17. -A MA documented as administered lorazepam 0.5mg on 11/26/17 at 8:35 am, 11:00am, and 7:08 pm. -There was not a fourth dose documented as administered for 11/26/17. -A MA documented as administered lorazepam 0.5mg on 11/29/17 at 8:44 am, 11:25 am, 3:52 pm and 7:14 pm. -A fifth dose of lorazepam 0.5 mg was documented as administered by a MA on 11/29/17 at 8:31 pm. Review of Resident #7's eMAR for December 2017 revealed: -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 12/14/17. -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 12/17/17. Review of the CSL for lorazepam 0.5mg administer 4 times daily, from 11/29/17 through 12/14/17 revealed: -A MA documented as administered lorazepam 0.5mg on 12/14/17 at 9:42 am, 12:09 pm, and 4:13 pm. -There was no fourth dose documented as administered for 12/14/17. Review of the CSL for lorazepam 0.5mg administer 4 times daily, from 12/15/17 through 12/22/17 revealed: -A MA documented as administered lorazepam 0.5mg on 12/17/17 at 8:19 am, 11:40 am, and 4:00 pm. -There was no fourth dose documented as	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/22/2017
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
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D 367	Continued From page 72 administered for 12/17/17. Observation of Resident #7's medications available on hand on 12/21/17 at 4:52 pm revealed there were 34 tablets of lorazepam 0.5mg remaining on card one, and 60 tablets of lorazepam 0.5 mg remaining on card two, for a total of 94 tablets of lorazepam 0.5 mg available. This matched the count on the controlled substance log. However, if administered correctly according to the eMAR, there should have only been 81 tablets available for administration. Interview on 12/21/17 at 4:50 pm with a second shift MA revealed: -Resident #7 received lorazepam 0.5 mg tablets 4 times a day scheduled at 8 am, 12 pm, 4 pm, and 8 pm. -Two doses would be given by 1st shift and two doses by 2nd shift. -She was always careful to sign out the medication on the controlled substance log when she pulled it from the cart to administer. -She did not mark the medication as administered on the eMAR until the resident had taken the medication. -She thought some MAs might have forgotten to sign the controlled substance sheet when they gave the medication. -She never documented a medication on the eMAR unless she had given it first. -She did not know why the controlled substance logs did not match the eMAR. Interview on 12/22/17 at 11:50 am with Resident #7 revealed: -He took lorazepam 0.5 mg tablets to help with symptoms from his Parkinson's Disease. -He took the lorazepam four times a day after meals and before bed.	D 367			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
(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 367	Continued From page 73 -He took several different medications several times a day, so he would be unaware if his lorazepam was not included with his other medications. -He was not sure if he got his lorazepam at the scheduled times each day or not. -He felt that his Parkinson's Disease symptoms were stable at this time. Refer to interview on 12/20/17 at 10:30 am with a Medication Aide/Supervisor (MAS). Refer to interview on 12/21/17 at 12:30 pm with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:32 pm with the Director of Clinical Services. Interview on 12/20/17 at 10:30 am with a Medication Aide/Supervisor (MAS) revealed: -The facility used an electronic Medication Administration Record (eMAR) system. -Routinely, there was one medication aide (MA) passing medications in the Special Care Unit (SCU) and one MA passing medications in the Assisted Living unit (AL) for the first shift. -Routinely, there was MA passing medications in both the SCU and AL for the second and third shifts. -The residents' medications appeared on the computer screen one hour before to one hour after the scheduled medication administration time. -If medications were not administered during the one hour before or one hour after time frame, the medications no longer appeared on the computer screen for administration but did show up on a separate screen for missed medications. -MAS were supposed to check the missed medication screen during and prior to ending their	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078
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D 367	Continued From page 74 shift to make sure all medications had been administered. -MA were supposed to sign out controlled medications and document on the eMAR at the time of administration. -The MA staff were not always checking the missed medications screen on the eMAR. -The residents probably did not get the medication if it was not documented on the eMAR (which would show up as a blank space on the eMAR. -For a controlled drug documented on the Controlled Substance log (CSL) but not on the eMAR, then the MA may not have checked the missed medication screen for documenting on the eMAR when it was signed out on the CSL. Interview on 12/21/17 at 12:30 pm with the Director of Clinical Services revealed: -The medication aides (MA) were responsible to reconcile the controlled substances sheets between shifts. -The MA looked for quantity on hand to match the Controlled Substance log (CSL) count. -The Resident Care Director (RCD) was responsible for the daily quality assurance checks. -The facility did not currently have a system in place to routinely monitor the documentation of administration of controlled substances compared to the CSL. -She had recently audited the residents' eMARs for completeness (holes) and filled in missing holes with "did not administer" due to the inability to confirm administration. -The Corporate Nurse came to the facility to do random record audits for medication and treatment orders, but might not have checked to see if the physician was faxed as ordered. -The Director of Clinical Services had been	D 367		

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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
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D 367	Continued From page 75 spending additional time in the facility until the new RCD started working next week (12/26/17). -A corporate nurse had been assigned, during the last 4 weeks, to assume the duties of the RCD and serve as the Interim RCD. -The Interim RCD was on leave and not available for interview. -A new RCD had been hired and scheduled to start to work next week (12/26/17). Interview on 12/22/17 at 12:32 pm with the Director of Clinical Services revealed: -The MAs were supposed to reconcile the eMARs and controlled substance logs at each shift change. -The Resident Care Director (RCD) was responsible for daily Quality Assurance and routine monitoring for all controlled substances in the building. -She did not know why the eMARs and controlled substance logs did not match for the months of September, October, November or December 2017.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure records of the receipt and administration of controlled	D 392	Immediate training of MTs and SICs was completed by the RCD and DOCS during the survey. This training included proper narcotic management with a focus around proper and immediate documentation on both the eMAR and the declining balance sheet. This will be monitored weekly on a random basis by the RCD and/or Regional Nurse (RN) to ensure ongoing compliance. Additionally,	22-Feb-18 and ongoing

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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078			
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D 392	Continued From page 76 substances were maintained, accurate and reconciled for 4 of 7 residents (#1, #7, #8, #9) sampled who were prescribed controlled substances including lorazepam, and oxycodone. The findings are: Review of the facility Narcotic Control Safety Measures Policy revealed: - "Each time a dose is administered, the Med Tech must document the dose on the relevant count sheet along with the remaining inventory of the narcotic left in stock". - "All Medication Technicians must ensure a shift to shift count occurs wherein the total count and content of each narcotic container is verified. Both the exiting Med tech and the arriving Med tech must sign the narcotic inventory control sheet verifying the count is correct". - "Should any variances be identified during the narcotic count, both team members are to notify their immediate supervisor at the time the variance is identified. Failure to notify your supervisor at the time a variance is identified will result in disciplinary action". A. Review of Resident #8's current FL-2 dated 2/15/17 revealed - Diagnoses included Alzheimer's dementia, mood disorder, and anxiety. - There was an order for Ativan 0.5 mg (used to treat anxiety) one tablet 3 times a day. (Lorazepam is generic for Ativan). - There was an order for Ativan 0.5mg one tablet 3 times daily as needed for anxiety. Review of Resident #8's record revealed signed physician's orders dated 05/23/17 as follows: - There was an order for lorazepam 0.5 mg (used to treat anxiety) one tablet 3 times a day.	D 392	the RCD will also conduct Medication Pass Observations with MTs and SICs to monitor proper documentation with medications administered, to include narcotics. As an additional control, the RCD will conduct weekly narcotic counts on every narcotic for 4 weeks and then randomly thereafter.				

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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078		
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D 392	Continued From page 77 -There was an order for lorazepam 0.5mg one tablet 3 times daily as needed for anxiety. Review of Resident #8's record revealed a subsequent physician's order dated 5/25/17 to discontinue lorazepam 0.5 mg as needed. Review of Resident #8's electronic Medication Administration Record (eMAR) for November 2017 revealed: -Lorazepam 0.5 mg, one tablet 3 times a day, hold for sedation, was transcribed and documented for administration 90 of 90 opportunities from 11/01/17 to 11/30/17 as scheduled. Review of Resident #8's CSL (Controlled Substance Log) for lorazepam 0.5 mg available for review compared to the November 2017 eMAR revealed there were 12 doses documented as administered on the eMAR but not documented as administered on Resident #8's CSLs. Telephone interview on 12/21/17 at 4:30 pm with a contract pharmacy representative regarding lorazepam 0.5 mg dispensed for Resident #8 revealed: -The pharmacy dispensed 90 lorazepam 0.5 mg on 9/11/17 (one bubble pack of 60 tablets plus one bubble pack of 30 tablets). -The pharmacy dispensed 90 lorazepam 0.5 mg on 10/17/17 (one bubble pack of 60 tablets plus one bubble pack of 30 tablets). -The pharmacy dispensed 90 lorazepam 0.5 mg on 11/10/17 (one bubble pack of 60 tablets plus one bubble pack of 30 tablets). -The pharmacy dispensed 90 lorazepam 0.5 mg on 12/01/17 (one bubble pack of 60 tablets plus one bubble pack of 30 tablets). (These tablets	D 392		

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D 392	Continued From page 78 were located on the medication cart as overstock). Observation on 12/21/17 of medication on hand for administration and Controlled Substance Logs (SCL) revealed: -The 90 lorazepam 0.5 mg dispensed on 10/17/17 had CSL sheets and all tablets could be accounted for. -The 90 lorazepam 0.5 mg dispensed on 11/10/17 had CSL sheets and all tablets could be accounted for. -The 90 lorazepam 0.5 mg dispensed on 12/01/17 had CSL sheets and all tablets could be accounted for. (These tablets were located on the medication cart as overstock). -The 90 lorazepam 0.5 mg dispensed on 9/11/17 had one CSL for 30 tablets that could not be located and was not accounted for and the 30 lorazepam 0.5 mg tablets were not on hand. Review of Resident #8's electronic Medication Administration Record (eMAR) for November 2017 revealed: -Lorazepam 0.5 mg, one tablet 3 times a day, hold for sedation, was transcribed and scheduled for administration at 8:00 am, 2:00 pm and 8:00 pm. -Lorazepam 0.5 mg was documented for administration 90 of 90 opportunities from 11/01/17 to 11/30/17. Review of Resident #8's CSL for lorazepam 0.5 mg available for review compared to the November 2017 eMAR revealed there were 12 doses documented for administration on the eMAR but not signed out on Resident #8's CSLs. Examples of the dates and times documented on the November eMAR but not accounted for on the	D 392			

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D 392	Continued From page 79 available CSL were as follows: -On 11/11/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 11/12/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 11/13/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 11/19/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 11/23/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 11/27/17 at 2:00 pm- administration documented on eMAR- not located on CSL. Review of Resident #8's eMAR for December 2017 revealed: -Lorazepam 0.5 mg, one tablet 3 times a day, hold for sedation, was transcribed and scheduled for administration at 8:00 am, 2:00 pm and 8:00 pm. -Lorazepam 0.5 mg was documented for administration 60 of 60 opportunities from 12/01/17 to 12/20/17. Review of Resident #8's CSL for lorazepam 0.5 mg available for review compared to the December 2017 eMAR revealed there were 10 doses documented for administration on the eMAR but not signed out on Resident #8's CSLs. Examples of the dates and times documented on the December 2017 eMAR but not accounted for on the available CSL were as follows: -On 12/02/17 at 8:00 am and at 2:00 pm- administration documented on eMAR- not located on CSL. -On 12/03/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 12/07/17 at 2:00 pm- administration documented on eMAR- not located on CSL.	D 392		

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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078
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D 392	Continued From page 80 -On 12/13/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 12/16/17 at 2:00 pm- administration documented on eMAR- not located on CSL. -On 12/17/17 at 2:00 pm- administration documented on eMAR- not located on CSL. Review of Resident #8's Controlled Substance logs (CSL) for lorazepam 0.5 mg, administered one tablet 3 times a day revealed on 12/12/17, a total of 4 tablets were documented as administered on the CSL; one tablet at 9:20 (no am or pm documented) on the CSL for 30 of 90 tablets dispensed on 11/10/17, and one tablet at 9:20 am, at 1:50 pm, and at 7:10 pm on the CSL for 60 of 90 lorazepam 0.5 mg dispensed on 10/17/17. (Documented for administration at 9:20 on two separate CSL counts. Based on record review and observation of Resident #8 on 12/21/17, it was determined the resident was not interviewable. Attempted telephone interview on 12/22/17 at 11:15 am with Resident #8's power of attorney was unsuccessful. A message was left and no phone call returned as of exiting the facility on 12/22/17 at 2:20 pm. Refer to interview on 12/20/17 at 10:30 am with a Medication Aide/Supervisor (MAS). Refer to interview on 12/21/17 at 12:30 pm with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:32 pm with the Director of Clinical Services. B. Review of Resident #9's current FL-2 dated 9/13/17 revealed;	D 392		

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NAME OF PROVIDER OR SUPPLIER
CARILLON ASSISTED LIVING OF HUNTERSVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
**250 COMMERCE CENTER DRIVE
HUNTERSVILLE, NC 28078**

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D 392	Continued From page 81 -Diagnoses included Alzheimer's dementia, congestive heart failure, and skin cancer. -The resident's level of care was special care unit. 1. Review of Resident #9's current FL-2 dated 09/13/17 and signed physician's orders dated 11/13/17 revealed: -There was an order for lorazepam 1 mg (used to treat anxiety) one tablet before supper and before bedtime. -There was an order for lorazepam 1 mg one tablet once daily PRN (as needed) for agitation. Telephone interview on 12/21/17 at 4:30 pm with a contract pharmacy representative regarding lorazepam 1 mg dispensed for Resident #9 revealed the pharmacy dispensed 60 lorazepam 1 mg on 10/20/17 (one bubble pack of 60 tablets). Review of Resident #9's medication on hand on 12/20/17 revealed a container of lorazepam 1 mg labeled for 60 tablet dispensed on 11/24/17 from a local pharmacy with 4 tablets remaining which matched the Controlled Substance Log (CSL) maintained by the facility. Review of Resident #9's electronic Medication Administration Record (eMAR) for November 2017 revealed: -Lorazepam 1 mg, one tablet before supper and before bedtime, was transcribed and scheduled for administration at 4:30 pm and 8:00 pm. -Lorazepam 1 mg one tablet once daily as needed for agitation was listed and scheduled PRN (as needed). -Lorazepam 1mg was documented as administered 51 of 60 scheduled opportunities from 11/01/17 to 11/30/17.	D 392		

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D 392	Continued From page 82 -There were 5 doses of lorazepam 1.0 mg documented as administered PRN on the November eMAR and CSL. Review of Resident #9's CSL for lorazepam 1 mg available for review compared to the November 2017 eMAR revealed: -There were 7 scheduled doses documented not administered on the eMAR, and documented as not administered on Resident #9's CSL. -There were 2 scheduled doses, 8:00 pm on 11/24/17 and 8:00 pm on 11/29/17, documented as not administered on the November eMAR but documented (signed out) as administered on the resident's CSL. Review of Resident #9's eMAR for December 2017 revealed: -Lorazepam 1 mg, one tablet before supper and before bedtime, was transcribed and scheduled for administration at 4:30 pm and 8:00 pm. -Lorazepam 1 mg one tablet once daily as needed for agitation was listed and scheduled PRN (as needed). -Lorazepam 1.0 mg was documented for administration 40 of 40 scheduled opportunities from 12/01/17 to 12/20/17. -There were 5 doses of lorazepam 1.0 mg documented as administered PRN on the November eMAR and CSL. Review of Resident #9's CSL for lorazepam 1 mg available for review compared to the December 2017 eMAR revealed on 12/05/17 one dose of lorazepam 1 mg was documented administered on the CSL at 12:30 pm (PRN), but not documented on the December 2017 eMAR. Review of Resident #9's medication on hand on 12/20/17 revealed a container of lorazepam 1 mg	D 392			

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D 392	Continued From page 83 labeled for 60 tablet dispensed on 11/24/17 from a local pharmacy with 4 tablets remaining which matched the CSL maintained by the facility. Based on record review and observation of Resident #9 on 12/21/17, it was determined the resident was not interviewable. Telephone interview on 12/22/17 at 1:15 am with Resident #9's family member revealed: -She was aware Resident #9 was out of at least one medication for one day (11/23/17) while new orders was being received. -She was not aware of any behaviors or increased anxiety that the resident had experienced. Refer to interview on 12/20/17 at 10:30 am with a Medication Aide/Supervisor (MAS). Refer to interview on 12/21/17 at 12:30 pm with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:32 pm with the Director of Clinical Services 2. Review of Resident #9's current FL-2 dated 09/13/17 and signed physician's orders dated 11/13/17 revealed: -There was an order for oxycodone 5 mg one tablet every 8 hours (scheduled). -There was an order for oxycodone 5 mg every 4 hours as needed for pain. Telephone interview on 12/21/17 at 4:30 pm with a contract pharmacy representative regarding oxycodone 5 mg dispensed for Resident #9 revealed the pharmacy dispensed 90 oxycodone 5 mg on 10/24/17. Review of Resident #9's electronic Medication	D 392		

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NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF HUNTERSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078
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D 392	Continued From page 84 Administration Record (eMAR) for November 2017 revealed: -Oxycodone 5 mg one tablet every 8 hours was transcribed and scheduled at 6:00 am, 2:00 pm, and 10:00 pm. -Oxycodone 5 mg one tablet every 4 hours as needed for pain was transcribed and scheduled as needed. -Oxycodone 5 mg was documented for administration 44 of 51 scheduled opportunities from 11/13/17 to 11/30/17. -There were 4 PRN (as needed) doses documented as administered on the eMAR with corresponding documentation for administration on the Controlled Substance Log (CSL). Review of Resident #9's CSL for oxycodone 5 mg compared to the November 2017 eMAR revealed: -There were 7 scheduled doses documented not administered on the eMAR and not signed out on Resident #9's CSL. -There were 2 scheduled doses, 6:00 am and 2:00 pm on 11/28/17, documented as not administered on the November eMAR but documented (signed out) as administered on the resident's CSL. Telephone interview on 12/21/17 at 4:30 pm with a contract pharmacy representative regarding oxycodone 5 mg dispensed for Resident #9 revealed the pharmacy dispensed 90 oxycodone 5 mg on 10/24/17 and none since. Review of Resident #9's CSL (CSL for 90 tablets dispensed on 10/24/17 and 90 tablets on 11/24/17) revealed 79 oxycodone 5 mg tablets were documented as administered from 11/01/17 to 11/30/17 compared to 83 oxycodone 5 mg tablets documented as administered on Resident #9's November 2017 eMAR.	D 392		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		A. BUILDING: _____		B. WING: _____		C 12/22/2017	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
CARILLON ASSISTED LIVING OF HUNTERSVILLE		250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078					
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D 392	Continued From page 85 Review of Resident #9's electronic Medication Administration Record (eMAR) for December 2017 revealed: -Oxycodone 5 mg one tablet every 8 hours was transcribed and scheduled at 6:00 am, 2:00 pm, and 10:00 pm. -Oxycodone 5 mg one tablet every 4 hours as needed for pain was transcribed and scheduled as needed. -Oxycodone 5 mg was documented for administration 52 of 55 scheduled opportunities from 12/1/17 to 12/20/17. -There were 11 PRN (as needed) doses documented as administered on the eMAR with corresponding documentation for administration on the CSL. Review of Resident #9's CSL for oxycodone 5 mg compared to the December 2017 eMAR revealed: -There were 3 scheduled doses, 10:00 pm on 12/7/17, 10:00 pm on 12/16/17, and 10:00 pm on 12/18/17, documented as not administered on the December eMAR, but documented (signed out) as administered on the resident's CSL. -There was one dose at 7:30 pm on 12/13/17 not documented as administered on the eMAR, but documented as administered on the CSL. Review of Resident #9's CSL (for 90 tablets dispensed on 11/24/17) revealed 63 oxycodone 5 mg tablets were documented as administered from 12/01/17 to 12/20/17 at 2:00 pm compared to 60 oxycodone 5 mg tablets documented as administered on Resident #9's December 2017 eMAR. Review of Resident #9's medication on hand on 12/20/17 revealed a container of oxycodone 5 mg	D 392					

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CARILLON ASSISTED LIVING OF HUNTERSVILLE

**250 COMMERCE CENTER DRIVE
HUNTERSVILLE, NC 28078**

(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 392	Continued From page 86 labeled for 90 tablet dispensed on 11/24/17 from a local pharmacy with 12 tablets remaining which matched the CSL maintained by the facility. Based on review of Resident #9's CSL and eMARs for November 2017 and December 2017, the facility failed to keep an accurate accounting for 4 oxycodone 5 mg in December 2017 and 4 oxycodone 5 mg tablets in November 2017. Based on record review and observation of Resident #9 on 12/21/17, it was determined the resident was not interviewable. Telephone interview on 12/22/17 at 1:15 am with Resident #9's family member revealed: -She was aware Resident #9 was out of at least one medication for one day (11/23/17) while new orders was being received. -She was not aware of any behaviors or increased anxiety that the resident had experienced. Refer to interview on 12/20/17 at 10:30 am with a Medication Aide/Supervisor (MAS). Refer to interview on 12/21/17 at 12:30 pm with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:32 pm with the Director of Clinical Services. C. Resident #1's current FL-2, dated 7/11/17, revealed: -Diagnoses included Alzheimer's Disease, anxiety, hypertension, bladder cancer, melanoma, peptic ulcer, vertigo, varicose veins. -The recommended level of care for Resident #1 was Special Care Unit.	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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NAME OF PROVIDER OR SUPPLIER
CARILLON ASSISTED LIVING OF HUNTERSVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
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D 392	Continued From page 87 Resident #1's current physician's orders, dated 10/26/17, revealed the following medication orders: -Lorazepam 0.5mg (used to treat anxiety), administered by mouth, once a day at 4:00 pm. -Lorazepam 0.5mg, by mouth, once a day as needed for anxiety. Review of Resident #1's Controlled Substance Log (CSL) for lorazepam 0.5mg, administered once daily at 4:00 pm revealed: -A medication aide (MA) documented as administered Lorazepam 0.5mg, administered daily at 4:00 pm, on 11/9/17 at 4:30 pm and also on 11/9/17 at 7:45 pm. Review of Resident #1's electronic Medication Administration Record (eMAR) for November 2017 revealed: -A different staff member than the one who documented as administered the lorazepam on 11/9/17 at 4:30 pm on the CSL, documented that it had been given at 4:00 pm. -There was no documentation lorazepam 0.5mg had been administered again at 7:45 pm on the eMAR. Review of the CSL for lorazepam 0.5mg (Dispensed 9/11/17 for 30 doses), administered once daily as needed for anxiety revealed a MA documented as administered lorazepam 0.5mg, administered once daily as needed for anxiety, on 11/07/17 at 2:00 pm and 11/11/17 at 2:00 pm. Review of Resident #1's eMAR for November 2017 revealed: -Neither of the lorazepam 0.5mg PRN doses documented as administered on the CSL for 11/07/17 or 11/11/17 had been documented on the November 2017 eMAR.	D 392		

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D 392	Continued From page 88 Review of the CSL for lorazepam 0.5mg (Dispensed 11/06/17 for 30 doses), administered once daily at 4:00 pm revealed the line at the 14th dose was left blank, with no explanation of where that pill had gone. Observation of Resident #1's medications available for administration on 12/22/17 at 10:00 am revealed there were 13 tablets of lorazepam 0.5mg, to be administered daily at 4:00 pm, remaining on the card of 30 doses dispensed on 11/06/17 matching the amount on hand. Interview on 12/22/17 at 10:00 am with a Medication Aide (MA) revealed: -She was not aware that there was a blank left on the control sheet at the 14th dosage for lorazepam 0.5mg, administered once daily at 4:00 pm. -She thought the 2nd shift MA, who would typically administer a 4:00 pm medication had probably forgot to sign it out that day. Refer to interview on 12/20/17 at 10:30 am with a Medication Aide/Supervisor (MAS). Refer to interview on 12/21/17 at 12:30 pm with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:32 pm with the Director of Clinical Services. D. Resident #7's current FL-2 dated 2/28/17 revealed diagnoses of Parkinson's disease, benign prostatic hyperplasia, and history of colon cancer. Review of Resident #7's record revealed a	D 392		

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D 392	Continued From page 89 current prescription, dated 9/12/17, for lorazepam 0.5mg, (used to treat anxiety), 4 times a day. Review of Resident #7's electronic Medication Administration Record (eMAR) for September 2017 revealed lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 9/27/17. Review of Resident #7's Controlled Substance Log (CSL) for lorazepam 0.5mg, administer 4 times daily, from 9/13/17 through 9/27/17 revealed: -A medication aide (MA) documented as administered lorazepam 0.5mg, on 9/27/17 at 8:58 am, 3:32 pm, and 8:06 pm. -There was not a fourth dose documented as administered for 9/27/17. Review of Resident #7's eMAR for October 2017 revealed: - Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 10/01/17. - Lorazepam had been documented as administered at 8:00 am, 4:00 pm, and 8:00 pm on 10/09/17. - Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 10/10/17. Review of the CSL for lorazepam 0.5mg, administer 4 times daily, from 9/28/17 through 10/13/17 revealed: -A MA documented as administered lorazepam 0.5mg on 10/01/17 at 11:41 am, 3:41 pm, and 7:15 pm. -There was not a fourth dose documented as administered for 10/01/17. -A MA documented as administered lorazepam	D 392		

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D 392	Continued From page 90 0.5 mg on 10/09/17 at 7:40 am and 8:00 pm. -There was not a third dose or fourth documented as administered for 10/09/17. - A MA documented as administered lorazepam 0.5 mg on 10/10/17 at 11:46 am, 2:00 pm, 3:25 pm, and 7:07 pm. -The administration times on 10/10/17 did not match the times given on the eMAR. Review of the CSL for lorazepam 0.5mg, administer 4 times daily, from 10/14/17 through 10/28/17 revealed no inaccuracies. Review of Resident #7's eMAR for November 2017 revealed: -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 11/05/17. -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 11/07/17. -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 11/17/17. -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 11/26/17. -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 11/29/17. -There was no fifth dose documented on the eMAR for 11/29/17. Review of the CSL for lorazepam 0.5mg, administer 4 times daily, from 10/29/17 through 11/14/17 revealed: -A MA documented as administered lorazepam 0.5mg on 11/05/17 at 10:00 am, 4:00 pm, and 7:00 pm. -There was not a fourth dose documented as	D 392		

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/22/2017
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D 392	Continued From page 91 administered for 11/05/17. -A MA documented as administered lorazepam 0.5mg on 11/07/17 at 11:09 am, 3:55 pm, and 7:36 pm. -There was not a fourth dose documented as administered for 11/07/17. Review of the CSL for lorazepam 0.5mg, administer 4 times daily, from 11/14/17 through 11/29/17 revealed: -A MA documented as administered lorazepam 0.5mg on 11/17/17 at 2:00 pm, 4:32 pm, and 7:04 pm. -There was not a fourth dose documented as administered for 11/17/17. -A MA documented as administered lorazepam 0.5mg on 11/26/17 at 8:35 am, 11:00am, and 7:08 pm. -There was not a fourth dose documented as administered for 11/26/17. -A MA documented as administered lorazepam 0.5mg on 11/29/17 at 8:44 am, 11:25 am, 3:52 pm and 7:14 pm. -A fifth dose of lorazepam 0.5 mg was documented as administered by a MA on 11/29/17 at 8:31 pm. Review of Resident #7's eMAR for December 2017 revealed: -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 12/14/17. -Lorazepam had been documented as administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm on 12/17/17. Review of the CSL for lorazepam 0.5mg administer 4 times daily, from 11/29/17 through 12/14/17 revealed: -A MA documented as administered lorazepam	D 392		

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D 392	Continued From page 92 0.5mg on 12/14/17 at 9:42 am, 12:09 pm, and 4:13 pm. -There was no fourth dose documented as administered for 12/14/17. Review of the CSL for lorazepam 0.5mg administer 4 times daily, from 12/15/17 through 12/22/17 revealed: -A MA documented as administered lorazepam 0.5mg on 12/17/17 at 8:19 am, 11:40 am, and 4:00 pm. -There was no fourth dose documented as administered for 12/17/17. Observation of Resident #7's medications available on hand on 12/21/17 at 4:52 pm revealed there were 34 tablets of lorazepam 0.5mg remaining on card one, and 60 tablets of lorazepam 0.5 mg remaining on card two, for a total of 94 tablets of lorazepam 0.5 mg available. This matched the count on the controlled substance log. Based on the eMAR and dispensed dates, if administered correctly, there should have been 81 tablets available for administration. Instead, based on the documentation of the controlled log and the medication on hand, there were 94 tablets of lorazepam available for administration. Interview on 12/21/17 at 4:50 pm with a second shift MA revealed: -Resident #7 received lorazepam 0.5 mg tablets 4 times a day scheduled at 8 am, 12 pm, 4 pm, and 8 pm. -Two doses would be given by 1st shift and two doses by 2nd shift. -She was always careful to sign out the medication on the controlled substance log when she pulled it from the cart to administer.	D 392		

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D 392	Continued From page 93 -She did not mark the medication as administered on the eMAR until the resident had taken the medication. -She thought some MAs might have forgotten to sign the controlled substance sheet when they gave the medication. -She never documented a medication on the eMAR unless she had given it first. -She did not know why the controlled substance logs did not match the eMAR. Interview on 12/22/17 at 11:50 am with Resident #7 revealed: -He took lorazepam 0.5 mg tablets to help with symptoms from his Parkinson's Disease. -He took the lorazepam four times a day after meals and before bed. -He took several different medications several times a day, so he would be unaware if his lorazepam was not included with his other medications. -He was not sure if he got his lorazepam at the scheduled times each day or not. -He felt that his Parkinson's Disease symptoms were stable at this time. Refer to interview on 12/20/17 at 10:30 am with a Medication Aide/Supervisor (MAS). Refer to interview on 12/21/17 at 12:30 pm with the Director of Clinical Services. Refer to interview on 12/22/17 at 12:32 pm with the Director of Clinical Services. Interview on 12/20/17 at 10:30 am with a Medication Aide/Supervisor (MAS) revealed: -If medications were not administered during the one hour before or one hour after time frame, the medications no longer appeared on the computer	D 392			

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D 392	Continued From page 94 screen for administration but did show up on a separate screen for missed medications. -For a controlled drug documented on the Controlled Substance Log (CSL) but not on the eMAR, then the MA may not have checked the missed medication screen for documenting on the eMAR when the medication was documented as administered on the CSL. -MA were supposed to document administration of the controlled medications on the Controlled Substance Log (CSL) and document on the eMAR at the time of administration. -The MA staff were not always checking the missed medications screen on the eMAR. -The residents probably did not get the medication if it was not documented on the eMAR (which would show up as a blank space on the eMAR). Interview on 12/21/17 at 12:30 pm with the Director of Clinical Services revealed: -The MA looked for quantity on hand to match the Controlled Substance Log (CSL) count. -The Resident Care Director (RCD) was responsible for the daily quality assurance checks. -The facility had a lot of unfiled documentation, including CSL sheets, which had been found in boxes and drawers. -She was able to locate most of the CSL but others may still be unfiled or misfiled. -The facility did not currently have a system in place to routinely monitor the documentation of administration of controlled substances compared to the CSL. -The Corporate Nurse came to the facility to do random record audits for medication and treatment orders, but might not have checked to see if the physician was faxed as ordered. -The Director of Clinical Services had been	D 392		

Division of Health Service Regulation

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D 392	Continued From page 95 spending additional time in the facility until the new RCD started working next week (12/26/17). -A corporate nurse had been assigned, during the last 4 weeks, to assume the duties of the RCD and serve as the Interim RCD. -The Interim RCD was on leave and not available for interview. Interview on 12/22/17 at 12:32 pm with the Director of Clinical Services revealed: -The MAs were supposed to reconcile the eMARs and Controlled Substance Logs at each shift change. -The Resident Care Director (RCD) was responsible for daily Quality Assurance and routine monitoring for all controlled substances in the building. -She had not heard any reports or concerns of mismanagement of controlled substances in the facility. -She did not know why the eMARs and controlled substance logs did not match for the months of September, October, November or December 2017.	D 392		
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 record review and interviews, the facility failed to assure every resident had the	D912	The ED, RCD and/or designee will conduct staff training regarding Resident Rights and the ownership of staff to ensure there are no violations of these rights.	22-Feb-18 and ongoing

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D912	Continued From page 96 right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration, personal care and supervision, and health care. The findings are: A. Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 1 of 1 sampled residents with falls (Resident #2). [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation).] B. Based on observations, interviews, and record reviews, the facility failed to implement physicians' orders for 2 of 5 sampled residents regarding thrombo-embolic deterrent (TED) hose, a chair alarm, bed alarm and hipsters (Resident #2), and compression stockings (Resident #1). [Refer to Tag D0276, 10A NCAC 13F .0902(c) (3-4) Health Care (Type B Violation).] C. Based on observations, interviews, and record reviews, the facility failed to assure staff documented the administration of medications immediately following the administration and observation of the resident actually taking the medications for 1 of 7 sampled residents regarding a resident (Resident #1) with medications found in the resident's room including cardiac and blood pressure medications which resulted in hospitalization, and an anti-anxiety medication. [Refer to Tag D0366, 10A NCAC 13F .1004(i) Medication Administration (Type B Violation)].	D912		