STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036016	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF CRAMER MC	500 CRAMER MOUNTAIN ROAD CRAMERTON, NC 28032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual survey on October 16-17, 2018.	D 000		
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 record reviews and interviews, the facility failed to notify the physician Coumadin 2mg was not administered for three consecutive days for 1 of 5 sampled residents (Resident #2). The findings are: 1. Review of Resident #2's current FL2 dated 12/19/18 revealed: -Diagnoses included atrial fibrillation, hypertension and dementia. -There was a medication order for Coumadin 2mg (an anticoagulant used to prevent strokes) daily. Review of a INR laboratory test dated 10/03/18 (INR are labs used to determine a person's blood clotting time) revealed: -The INR result was 1.9. -There was a note in the comments section of the lab report faxed from the physician office to continue Coumadin 2mg and recheck INR in one week (10/11/18). Review of an INR laboratory results collected on	D 273		

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D 273	Continued From page 1 10/11/18 revealed: -The INR results was 1.6. -There was a note in the comments section of the lab report faxed from the physician office to increase the Coumadin from 2mg to 2.5mg daily and recheck INR in one week (10/18/18). Review of the electronic Medication Administration Record (eMAR) for the month of October 2018 revealed: -There was an entry for Coumadin 2mg daily scheduled to be administered at 8:00pm. -There was documentation Coumadin 2mg was administered from 10/01/18 through the 10/07/18. -There was documentation Coumadin 2mg was held on 10/08/18 through 10/10/18 "resident refused". -There was an entry dated 10/11/18 for Coumadin 2.5mg daily. -There was documentation Coumadin 2.5mg was administered from 10/11/18 through 10/15/18. Telephone interview with Resident #2's physician's office nurse revealed: -Neither the physician nor the office staff were notified Resident #2 had missed Coumadin 2mg for three days in October 2018. -The physician would want to know if Resident #2 had missed Coumadin for three consecutive days. -"Coumadin is monitored by lab work to determine the dose and to keep the resident's blood level therapeutic." -The facility was responsible for informing the physician of any missed medications," especially Coumadin". Observation of medications on hand for Resident #2 revealed Coumadin 2mg tablets were available for administration.	D 273		

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D 273	Continued From page 2 Interview with a medication aide (MA) on 10/16/18 at 2:00pm revealed: -She knew Resident #2 was on Coumadin, "It is for his heart". -She did not know Coumadin 2mg was not administered to Resident #2 for three days 10/08/18 through 10/10/18. -It was the responsibility of the MA to call the physician if a resident missed their medications. -The facility policy was if a resident missed three consecutive days taking medications the physician was to be notified. -"The physician should had been called for the missed doses of Coumadin." -"I would had called if Resident #2 had refused Coumadin the first day, it's that important." -The Resident Care Director (RCD) was responsible for reviewing the eMAR. Interview with a second MA on 10/16/18 at 2:25pm revealed: -The residents often refused medications on her shift. -When a resident refused to take their medications she would try again to administer the medications in 15 minutes or get another MA to try and administer the medications. -She did not know Resident #2 had not received Coumadin for three consecutive days 10/08/18 through 10/10/18. -The facility policy was if a resident missed three consecutive days taking medications the physician was to be notified. -"The physician dosed the amount of Coumadin to administer by monthly lab work; if the Coumadin is not given then the labs will be off." Telephone interview with a third MA on 10/16/18 at 2:43pm revealed:	D 273		

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-She had worked the three days Resident #2 had refused the medication Coumadin 2mg.
-"[Resident #2] would not take the Coumadin."
-She had not contacted the physician in regard to Resident #2 refusing the Coumadin.
-She had not informed the RCD or the Executive Director Resident #2 was not administered the Coumadin.
-She had not realized the Coumadin was missed for three consecutive days until 10/16/18.
-She knew the facility had a policy to contact the physician if a resident missed taking medications for three consecutive days.

Interview with the Special Care Unit Coordinator (SCUC) on 10/16/18 at 2:30pm revealed:
-She did not know Resident #2 was not administered Coumadin 2mg for three consecutive days 10/08/18 through 10/10/18.
-The RCD was responsible for all resident's medications and medication orders.
-She thought the policy was if a resident missed three consecutive days taking medications the physician was to be notified.
-She did not know the physician was not notified Resident #2 had not received Coumadin for three days in October 2018.

Interview with the RCD on 10/16/18 at 2:35pm revelaed:
-She was responsible for reviewing medication orders and medication management.
-She did not know Resident #2 was not administered Coumadin 2mg three days from 10/08/18 through 10/10/18.
-The MAs were to contact the physician when a resident missed three consecutive days taking their medications.
-She was unsure why the physician was not made aware Resident #2 had not been

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D 273	Continued From page 4 administered Coumadin 2mg for three days. -The MAs were trained on the process to contact the physician when a resident did not take medications for three days in a row. Interview with the Executive Director on 10/16/18 at 2:50pm revealed: -The facility trained the MA on the process of contacting the physician if a resident missed medications for three consecutive days. -She did not know Resident #2 had three consecutive days 10/08/18 through 10/10/18 the Coumadin was not administered. -She did not know the physician was not contacted for the missed medication Coumadin.	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to have a matching therapeutic diet menu for 2 of 5 sampled residents (Resident #1 and #3) with orders for a no concentrated sweets (NCS) diet for Resident #1 and a blend all foods (puree) diet for Resident #3. Review of the facility menus on 10/16/18 at 9:45am revealed: -There was a Week at a Glance menu laying on	D 296		

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D 296	Continued From page 5	D 296		

the Dietary Manager's (DM) desk in the kitchen.
-All available menus were for a regular diet.
-There were no therapeutic menus available for guidance of the food service staff.

1. Review of Resident #1's current FL2 dated 11/01/17 revealed diagnoses of dementia and diabetes.

Review of Resident #1's signed physician's order dated 10/04/18 revealed a diet order for regular, blend all foods except bread (soften bread with liquid).

Review of the facility's therapeutic diet list posted in the kitchen dated 10/11/18 revealed Resident #1 was to be served a blend all foods (puree) diet.

Observation of the lunch meal service on 10/16/18 from 11:55am to 12:41pm revealed:
-Resident #1 was served pureed collard greens, pureed sweet potatoes, pureed ham, sugar free applesauce, tea, water and milk.
-Each food was in an 8 ounce glass with a straw.
-Resident #1 consumed 10% of collard greens, 100% of sweet potatoes, 50% of ham, 50% of applesauce, 100% of water, 50% of tea and none of the milk.
-Without a therapeutic diet menu, it could not be determined if Resident #1 was served the blend all foods (puree) diet as ordered by the physician.

Observation of the breakfast meal service for 10/17/18 from 8:10am to 8:30am revealed Resident #1 ate breakfast in her room.

Interview with the medication aide (MA) on 10/17/18 at 8:15am revealed Resident #1 remained in bed until 10:30am every morning and

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D 296	Continued From page 6 did not eat breakfast at the family's request. Telephone interview with Resident #1's responsible party on 10/16/18 at 4:45pm revealed she had requested Resident #1 to have her food served in glasses for her to drink. Observation of the dietary notebook produced by the Regional Director on 10/16/18 at 3:33pm revealed the Regional Director presented references used by the dietary staff when prepping and serving food. Review of the dietary notebook revealed: -The information included recipes and a summary of the therapeutic diets available with general guidance on how to serve the diets and did not include therapeutic diet menus. -The therapeutic diet menus were located in the back of the notebook. Observations of the kitchen on 10/17/18 at 3:30pm revealed the dietary notebook was open and available on the counter for dietary staff. Refer to interview with the DM on 10/16/18 at 11:41am and 10/17/18 at 10:40am. Refer to interview with the Administrator on 10/17/18 at 10:54am. Refer to interview with the Regional Director on 10/16/18 at 3:33pm. Refer to telephone interview with the Corporate Director of Dining Services on 10/17/18 at 1:05pm. 2. Review of Resident #3's current FL2 dated 08/21/18 revealed a physician's order for a NCS	D 296		

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D 296	Continued From page 7 diet. Review of the facility's therapeutic diet list posted in the kitchen dated 10/11/18 revealed Resident #3 was to be served a NCS diet. Observation of the lunch meal service on 10/16/18 from 12:15pm to 12:45pm revealed: -Resident #3 was served baked ham, sweet potatoes, collard greens, dinner roll, fruit cup and unsweetened tea with artificial sweetener. -The fruit cup contained mandarin oranges, grapes and pears. -Resident #3 consumed 100% of the ham, collard greens, roll and dessert and 50% of the sweet potatoes. -Without a therapeutic diet menu, it could not be determined if Resident #3 was served the NCS diet as ordered by the physician. Observation of the breakfast meal service for 10/17/18 from 8:10am to 8:30am revealed: -Resident #3 was served in her room. -Resident #3 was served pancakes with sugar free syrup and coffee. -Resident #3 consumed 100% of the pancakes and coffee. -Without a therapeutic diet menu, it could not be determined if Resident #3 was served the NCS diet as ordered by the physician. Observation of the dietary notebook produced by the Regional Director on 10/16/18 at 3:33pm revealed the Regional Director presented references used by the dietary staff when prepping and serving food. Review of the dietary notebook revealed: -The information included recipes and a summary of the therapeutic diets available with general	D 296		

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D 296	Continued From page 8 guidance on how to serve the diets and did not include therapeutic diet menus. -The therapeutic diet menus were located in the back of the notebook. Observations of the kitchen on 10/17/18 at 3:30pm revealed the dietary notebook was open and available on the counter for dietary staff. Refer to interview with the DM on 10/16/18 at 11:41am and 10/17/18 at 10:40am. Refer to interview with the Administrator on 10/17/18 at 10:54am. Refer to interview with the Regional Director on 10/16/18 at 3:33pm. Refer to telephone interview with the Corporate Director of Dining Services on 10/17/18 at 1:05pm. _____ Interview with the DM on 10/16/18 at 11:41am and 10/17/18 at 10:40am revealed: -She only used the Week at a Glance menu to prepare meals for the residents. -She served all residents the same food listed on the menu. -She tried to serve all the residents the same desserts to "make sure no one feels left out." -She served desserts that had no added sugars, if possible. -If a resident could not have something on the menu then she knew from her experience to "substitute it with something else." -She did not have to substitute menu items often. Interview with the Regional Director on 10/16/18 at 3:33pm revealed:	D 296		

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D 296	Continued From page 9 -The therapeutic diet menus were located in the DM's office in a notebook. -He did not know the DM was required to use therapeutic diet menus for guidance of food service staff. -He thought the general guidelines and recipes for therapeutic diet preparation provided the needed guidance. Telephone interview with the Corporate Director of Dining Services on 10/17/18 at 1:05pm revealed: -He was responsible for creating the facility's menus and recipes and a Registered Dietitian (RD) approved them. -He was responsible for providing training to all DMs. -He had provided "Phase 1" training to this facility's DM which included how to read the menus and recipes, how to utilize "the diet extensions menu" (menus for therapeutic diets) and information on state regulations. -The RD had approved therapeutic menus for both the "blended" (puree) diet and the NCS diet and he had provided these in a notebook to the DM during "Phase 1" of training. -The "blended" diet was the name they used for a puree diet. -The DM should always have the notebook open to the page with the therapeutic menus for her reference and for the reference of other kitchen staff to know what to serve to residents on the puree and NCS diets. -If she only used the regular diet Week at a Glance spreadsheet for guidance, dietary staff would not know to make substitutions for the puree diet such as mashed potatoes in place of rice, pureed green beans in place of corn and mashed potatoes in place of the fried vegetable sticks.	D 296		

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D 296	Continued From page 10 -He did not know why she was not utilizing the therapeutic menus for guidance, but he would provide her with more training. Interview with the Administrator on 10/17/18 at 10:54am revealed: -The facility provided 3 menu options, regular, NCS and puree. -She thought the NCS diet was the same as a regular diet. -She did not know a therapeutic menu needed to be followed for the blended foods (puree) diet. -She thought the only adjustment needed to be made was to puree all the same foods on the regular diet menu and did not know there were substitutes reflected on the therapeutic menu such as mashed potatoes for rice.	D 296		
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: Based on observations, record reviews and interviews, the facility failed to assure medication aides observed residents take their medications after administration for 1 of 5 sampled residents (Resident #5).	D 366		

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D 366	Continued From page 11 The findings are: Review of Resident #5's current FL2 dated 10/09/18 revealed: -Diagnoses included muscle weakness, lack of coordination, congestive heart failure (CHF), atrial fibrillation and hypertension. -There was a physician's order for amlodipine 2.5mg take 1 tablet daily for blood pressure, Eliquis 2.5mg take 1 tablet twice daily for atrial fibrillation (also used for thinning of blood), potassium chloride 20mEq take 2 tablets daily (supplement), furosemide 40mg take 1 tablet twice daily for CHF, and metoprolol ER 100mg take 1 tablet daily for blood pressure. Review of Resident #5's clarification order approved verbally by the primary care physician (PCP) on 10/13/18 revealed a physician's order for a senior multivitamin take 1 tablet daily. Review of Resident #5's standing orders signed by the physician on 10/09/18 revealed a physician's order for oral medications to be crushed and/or placed in applesauce, pudding or juice if not contraindicated by the pharmacy. Review of Resident #5's October 2018 electronic Medication Administration Record (eMAR) revealed: -The amlodipine, a senior multivitamin, Eliquis, furosemide, metoprolol, and potassium chloride were documented as administered on 10/16/18 at 8:00am. -There was no physician's order directing the Medication Aide (MA) to administer medications to resident in applesauce on eMAR. Observation of Resident #5's room on 10/16/18 at	D 366		

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D 366	Continued From page 12 9:57am revealed a medicine cup with 3 large tablets and multiple smaller tablets underneath sitting on Resident #5's nightstand. Review of Resident #5's physician's orders revealed there was no order for resident to self-administer medications. Interview with Resident #5 on 10/16/18 at 9:57am revealed: -She could not swallow the large tablets and had to have applesauce to take her medications. -The MA had brought her medications this morning without applesauce. -She told the MA that she could not take her medications without the applesauce. -She was planning to remind the MA to bring her applesauce so she could take her medications. Interview with the MA on 10/16/18 at 2:26pm revealed: -Resident #5 was admitted to the facility "a few days ago." -Today was the first time she had administered medications to Resident #5. -She did not know that Resident #5 wanted to take her medications with applesauce. -She did not have any applesauce on the medication cart during the med pass. -She had left Resident #5's medications on the nightstand to help the resident sit up in the bed. -She "forgot to go back with the applesauce" for Resident #5 to take her medications "until later in the morning." Interview with the Resident Care Director (RCD) on 10/17/18 at 10:48am revealed: -The MA was expected to observe the resident during the medication pass until the resident "took all their medications."	D 366		

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CARILLON ASSISTED LIVING OF CRAMER MC	500 CRAMER MOUNTAIN ROAD CRAMERTON, NC 28032

(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 13 -The MA should not be leaving medications in the room with the resident. -The MA was responsible for observing medication administration before documenting a medication as administered on the eMAR. -She did not know that Resident #5 wanted to take her medications with applesauce. -She or the Resident Care Coordinator (RCC) had to enter the request for applesauce into the computer for the MA on duty to know. Interview with the Administrator on 10/17/18 at 10:54am revealed: -She worked as a MA as needed in the facility. -The MA was responsible for making sure each resident took their medications during a med pass. -The MA was responsible for observing the resident until the resident was administered all their meds. -The MA was not supposed to leave any medications in a resident's room. -She was responsible for processing Resident #5's medications on admission. -She did not know that Resident #5 had requested to take her medications with applesauce.	D 366		