STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 and follow-up survey on March 22-24, 2017.	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: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure follow up and coordination of care needs for 1 of 5 sampled residents (Resident #3) with a physician's order for TED (Thrombo-Embolic Deterrent) hose daily. The findings are: Review of Resident #3's current FL-2 dated 10/03/2016 revealed: -Diagnoses included atrial fibrillation, cervical spinal stenosis, chronic kidney disease, hypotension, syncope, coronary atherosclerosis, coronary artery bypass graft thrombus with infarct, essential hypertension, and osteoporosis - fracture neck of femur. -There was a physician's order for TED knee highs - provide every morning and remove every night. Review of the Resident Register completed for Resident #3 revealed an admission date of 05/23/2014.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 1 Review of the current Care Plan assessment for Resident #3 dated 08/11/2016 revealed: -The resident required extensive assistance with dressing. -The resident was oriented. -The resident's memory was adequate. Review of a Licensed Health Professional Support (LHPS) review for Resident #3 dated 01/11/2017 revealed: -The LHPS Nurse documented the resident was not wearing TED hose. -The resident reported needing a new pair of TED hose. -The LHPS Nurse reported to the Assistant Resident Care Director (ARCD). -The LHPS Nurse assessed there to be 2+ non-pitting edema to the resident's ankles. Observations of Resident #3 on 03/22/2017 at 10:30am during the initial facility tour revealed: -The resident was sitting up on the side of the bed with her feet on the floor. -Both of the resident's feet and ankles were moderately swollen. -The resident was able to move her feet and toes. -The resident was wearing thin, brownish color knee high stockings that were torn along the side and around the top. Interview with Resident #3 on 03/22/2017 at 10:35am revealed: -The Personal Care Aide (PCA) was in the room to change the resident's wet bed linen. -The PCA was getting ready to help the resident get dressed. -The resident required assistance with everything except feeding. -The resident was supposed to wear TED hose,	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 2	D 273		

but was not wearing them.
-The resident's feet were "swollen to capacity, and they hurt".
-The facility had "not done anything" about the missing TED hose, and did not want the resident to do anything.

Interview with the PCA on 03/22/2017 at 10:40am revealed:
-The PCA believed Resident #3 was supposed to wear "support hose".
-The PCA believed the Medication Aides (MAs) were supposed to apply the TED hose.
-She had seen Resident #3 wearing brown hose.
-The PCA had been employed at the facility for about one month.

Observation of the PCA on 03/22/2017 at 10:45am revealed:
-The PCA checked the dresser drawers in the resident's room for "support hose".
-The PCA opened the right top dresser drawer and removed one knee length tan colored TED hose.
-There were no additional TED hose located in the resident's room.

Further interview with the PCA on 03/22/2017 at 10:55am revealed she believed the hose that Resident #3 was wearing were "regular knee high stockings".

Observation of Resident #3 on 03/22/2017 at 4:30pm revealed:
-The resident was sitting up in her wheelchair in her room.
-The resident was wearing thin, brownish color knee high stockings that were torn along the side and around the top.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 3 Interview with Resident #3 on 03/22/2017 at 4:30pm revealed: -She did not have any support hose to put on. -She only had the one hose that was in the dresser drawer. -She had only had the one pair of TED hose and somebody had gotten her other TED hose from the washing machine. -Her feet were hurting. -Her heels were "hurting" and were "cracked". -Her left heel was in "bad shape". -She wore TED hose when she had them. -It had been over two weeks or more since she'd had them. -There was "no need to say anything because they don't do anything about it". -She had not said anything about the TED hose. The Resident Care Director (RCD) and Clinical Director went to Resident #3's room on 03/22/2017 at 4:35pm upon request. Observation and interview with the Clinical Director on 03/22/2017 at 4:35pm revealed: -She assessed the resident to have 4+ edema in the feet and ankles. -The left ankle was more swollen than the right ankle. -The resident was wearing non-supportive knee high stockings. -Resident #3 informed the Clinical Director and RCD that her heels were sore, feet were "swollen to capacity", and that her left ankle hurt more than the right ankle. -The Clinical Director stated she would follow up and have the resident's feet and ankles assessed at a local urgent care facility due to the resident's complaint of pain. Interview with the RCD on 03/22/2017 at 4:35pm	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 4 revealed: -Resident #3 was supposed to have TED hose. -The RCD would have to order the resident another pair of TED hose. -The RCD was not aware Resident #3 had been without her TED hose. -The MAs were responsible for applying the TED hose. Review of Resident #3's March 2017 electronic Medication Administration Records (MARS) printed on 03/22/2017 revealed: -There was documentation that TED hose had been applied by a MA every morning from 03/01/2017 through 03/22/2017 at 8:00am. -There was documentation that TED hose had been removed a MA every evening from 03/01/2017 through 03/21/2017 at 8:00pm except for 03/11/2017 when the MA documented a symbol for missed dose. Interview with the Clinical Director on 03/23/2017 at 8:30am revealed: -Resident #3 was sent to a local urgent care facility on 03/22/2017 who suggested the resident be seen at the emergency room. -Resident #3 refused to go to the emergency room on 03/22/2017 for an assessment of her feet and ankles. -An appointment was scheduled on 03/22/2017 for the resident to be seen on 03/23/2017 at 3:30pm by her Primary Care Manager (PCM) for an assessment of the bilateral ankle edema and pain. Interview with the ARCD on 03/23/2017 at 10:30am revealed: -Staff reported on 03/22/2017 that one of Resident #3's TED hose had been gone for 1-2 weeks.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 5	D 273		

-No one else had reported to her the resident's TED hose were missing.
-To her knowledge, she did not recall the LHPS Nurse reporting on 01/11/2017 that Resident #3 needed another pair of TED hose.
-The facility RCD or ARCD were responsible for measuring residents for TED hose.
-TED hose were ordered for Resident #3 on the evening of 03/22/2017.
-She did not know when TED hose had been ordered for Resident #3 prior to 03/22/2017.

Interview with the Clinical Director on 03/23/2017 at 10:50am revealed:
-She could not answer why the ARCD did not remember the LHPS Nurse notification about Resident #3's TED hose.
-She believed the TED hose had been at the facility since 01/11/2017 when the LHPS Nurse completed the LHPS review but did not know the condition of the TED hose.
-She had spoken to a MA who said she had put the TED hose on Resident #3 on 03/15/2017.
-She did not know if anybody had followed through to see if the TED hose were in the facility.
-The LHPS Nurse was very thorough and she believed if the LHPS Nurse said she notified the ARCD, then she believed it.

Interview with the LHPS Nurse Consultant on 03/23/2017 at 11:15am revealed:
-She visited the facility weekly and performed initial and quarterly LHPS assessments and reviews.
-She reviewed the resident record to ensure she was not missing anything that needed to be addressed with the LHPS assessment and review.
-She did not think Resident #3 thought the TED hose were very comfortable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 6 -If she wrote that the resident said she needed a new pair of TED hose, then that was what the resident said when the LHPS nurse spoke with the resident during the 01/11/2017 LHPS assessment. -She let staff know the resident was not wearing the TED hose. -She did not search to see if the TED hose were in the drawers. -She had seen the resident wearing TED hose before. Confidential interviews with six staff revealed: -Resident #3 was supposed to wear TED hose. -When Resident #3 was administered her medication, MA's put on her TED hose. -There were times when staff had to look for the resident's TED hose. -Staff could not put the TED hose on if the staff could not locate them. -Resident #3 had a white pair and tan-brownish pair that looked like stockings but were thicker and shiny. -Staff were not sure, but thought about a week ago, Resident #3's TED hose were "torn, damaged". The staff remembered it had been a while since she had worked with Resident #3. -Resident #3 sometimes liked to get up late so staff applied the TED hose around 11 - 11:30am. -The MA's were responsible for applying and removing TED hose. -If Resident #3 had refused to have the TED hose applied it would be documented in a progress note. -When Resident #3's ankles were swollen, staff would get the resident to sit in the recliner and prop her feet up. -Resident #3 required encouragement to not sit in her wheelchair for long periods of time. -Most of the time they tried to keep an extra pair	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 7 of TED hose on the cart with the resident's name - "just like medicine, not supposed to give out". -Staff had not seen an extra pair of TED hose on the medication cart for Resident #3. -Resident #3 refused TED hose on 03/21/2017. -One staff stated the resident did not normally refuse to wear the TED hose. -Resident #3's feet would swell badly, and staff sometimes could not get the resident's bedroom shoes on, but normally staff could get her shoes on. -Resident #3 "had some sort of stocking on" on 03/20/2017 that was a "shiny brown stocking like hose". -The resident had bought some TED hose from home when the resident came to live at the facility. -Staff had seen the resident not wearing the TED hose but could not remember specific days. -There were days when the resident wanted to be warm and wore "regular sock". -Staff had not notified the physician of any refusals with regards to TED hose "get used to their behaviors sometimes". -Resident #3's left ankle was always "puffier" than the right ankle. -At night the resident would say her feet sting and would require more assistance. -Staff remembered putting a pair of hose on Resident #3 "that were tight but could not have been TED hose". -Staff had never seen Resident #3 take off her TED hose or move them down once they were on. -Staff remembered removing Resident #3's TED hose when working. -Staff remembered going in to Resident #3's room, resident would be in bed, and TED hose were not on. -One staff did not remember the last time she had	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 8 seen Resident #3's TED hose. Telephone interview with the staff from the PCM's office on 03/24/2017 at 9:00am revealed: -Resident #3 was seen at the physician's office on 03/23/2017. -The office staff did not know anything about any contact from the facility regarding Resident #3 refusing to wear TED hose, request for another order for TED hose, or any calls from facility to report swelling or pain in Resident #3's feet and ankles. Review of a copy of the 03/23/2017 physician visit report for Resident #3 revealed: -New symptoms were bilateral pedal edema but not shortness of breath and no chest pain. -Add Lasix (used to treat fluid retention) 20mg daily. -Request for fasting bloodwork. -Resident to return to office in 2 weeks. Telephone interview with Resident #3's Power of Attorney (POA) on 03/24/2017 at 9:20am revealed: -She visited the resident monthly and communicated with the resident by telephone. -The facility contacted her for anything out of the ordinary. -Resident #3's mind was "sound - she is able to articulate". -Sometimes the resident wore support hose if going somewhere. -She did not remember Resident #3 having to wear support hose on a regular basis. -She had never purchased support hose for Resident #3 and did not believe she had been asked to. -Resident #3 had always had swelling around the ankles.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 9 -The resident saying they were hurting was different and may be something new going on. -The resident may need support hose now. Telephone interview with a Pharmacy Provider Representative on 03/24/2017 at 9:30am revealed: -The pharmacy last sent a pair of TED hose to the facility for Resident #3 on 04/20/2016. -The pharmacy sent a pair of TED hose to the facility on 03/22/2017 for Resident #3. -The pharmacy sent a second pair of TED hose to the facility on 03/23/2017 for Resident #3. -TED hose were supposed to be replaced if there were holes or the TED hose had become stretched out. Interview with Resident #3 on 03/24/2017 at 9:40am revealed: -The facility staff transported her to the physician's office yesterday. -She was wearing TED hose that she got yesterday (03/23/2017). -She thought it had been approximately a month since she'd had TED hose. -Her feet were feeling alright. -She had never refused to wear the TED hose and would rather have them on. Interview with the RCD on 03/24/2017 at 10:20am revealed: -She or the Nurse Consultant completed the LHPS assessments and reviews. -The Nurse Consultant usually communicated verbally to the RCD or ARCD at the end of her visit the findings for those residents for which the LHPS Nurse had completed the LHPS assessment and review. -The RCD did not know the ARCD had been notified that Resident #3 was not wearing the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 10 TED hose on 01/11/2017 and needed a new pair. Interview with the Executive Director (ED) on 03/24/2017 at 11:30am revealed: -The ED understood the TED hose had been placed on the resident. -The ED described Resident #3 as "forgetful" then "occasionally forgetful". -Staff reported they had placed the TED hose on Resident #3 and Resident #3 did not remember. -The ED was not aware the LHPS Nurse documented Resident #3 stated she needed another pair of TED hose and had reported the same to the ARCD. -The ED had only been employed at the facility for about 3 weeks. _____ The facility neglected to follow up to replace Resident #3's "damaged, torn" TED hose and to apply TED hose as ordered resulting in increased swelling and pain in the resident's feet and ankles which is detrimental to the residents' health, and well-being. This constitutes a Type B Violation. _____ Review of the Plan of Protection submitted by the facility on 03/24/2017 revealed: -It was identified that certain staff were using nylon knee-highs the same color thinking they were TED Hose. Resident was sent to urgent care, they requested to have her seen in ER but she refused. Resident was sent and seen by her physician. -Upon learning on 03/22/17, 03/23/17, and 03/24/17, all residents with TED Hose orders were audited to ensure that they had them in their possession and they were on per physician orders and staff have participated in retraining as it pertains to TED Hose and their application.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 11 -All residents who are to wear TED hose per physician orders had had this reflected on their electronic personal care record. -Staff are to identify if not wearing to notify the Supervisor, Resident Care Director, Assistant Resident Care Director, and/or the Executive Director so that it can be addressed. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 8, 2017.	D 273		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, record reviews, and interviews, the facility failed to ensure follow up and coordination of care needs for 1 of 5 sampled residents (Resident #3) with a physician's order for TED (Thrombo-Embolic Deterrent) hose daily. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092159	A. BUILDING: _____ B. WING _____	R 03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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