STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF CLEMMONS	1165 S PEACE HAVEN RD CLEMMONS, NC 27012

(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 March 22-23, 2017.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications and treatments were administered as prescribed to 2 of 6 residents (#6 and #7), regarding Preservision Lutein vitamin and omeprazole, observed during medication administration. The findings are: The medication error rate was 5% based on the observation of 2 errors out of 24 opportunities during the morning medication pass on 03/23/17. A. Review of Resident #6's current FL-2 dated 02/22/17 revealed: -Diagnosis included macular degeneration. -An order for Preservision Lutein one tablet daily. (Preservision Lutein is a vitamin supplement used in treatment of macular degeneration.) Observation of the morning medication pass on	D 358	**Plan:** The facility will ensure medications and treatments, prescriptions, non-prescriptions and treatment by staff are delivered in accordance with orders by a licensed prescribing physician and within the rules of 10A NCAC 13F.1004 Medication Administration section and the facility's policies and procedures. The facility will provide additional training to all medication technicians and resident care staff to reiterate expected best practices and parameters for administering medication. The Resident Care Director, Resident Care Coordinator and other credentialed representatives will conduct additional training and monitoring of medication technicians as a proactive effort to ensure proper administration of medication and compliance with the rules and procedures required. The Resident Care Director and other credentialed staff will continue to complete medication verification per order by the physician to ensure proper medication orders are delivered in accordance with the order. The Resident Care Director,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Richardson — TITLE: Executive Director — (X6) DATE: 5/4/2017

Reviewed and accepted 05/08/17 *HRP* hrp

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D 358	Continued From page 1 03/23/17 at 8:20 am revealed: -The day shift medication aide (MA) prepared 7 oral medications for administration to Resident #6. -The MA reviewed the scheduled medications displayed on the monitor for the eMAR computer. -The MA used the bar code scanner and the medication packaging (bingo cards) to prepare Resident #6's medications for administration. -The count for the number of medications prepared from the medication cards were verified with the MA prior to administration -The MA administered the medications, along with 4 ounces of water, to Resident #6 at the medication cart in Hall D hallway. -Preservision Lutein was not included in the medications administered to Resident #6. Review of Resident #6's record revealed no subsequent physician's order to discontinue Preservision Lutein vitamins. Review of Resident #6's electronic Medication Administration Record (eMAR) on 03/23/17 at 9:22 am revealed: -An entry for Preservision Lutein, scheduled for administration at 8:00 am and documented as administered at 8:00 am on 03/23/17. Observation on 03/23/27 at 10:45 am of medication on hand for administration for Resident #6 revealed: -A bingo card labeled Preservision Lutein dispensed on 03/04/17 for a quantity of 30 capsules. -Twenty three capsules remained in sealed bubble slots. -The card had a date of 03/16/17 and initials on the left side of the card.	D 358	**Plan** (cont'd): Resident Care Coordinator and other credentialed staff will conduct weekly cart audits to ensure all medication orders prescribed by the physician are correct and available. **Completion Date** **Responsible Parties:** Executive Director Resident Care Director	04/30/17

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D 358	Continued From page 2 Interview on 03/23/17 at 10:45 am with the MA revealed: -She administered Resident #6's medication at 8:20 am on 03/23/17. -She reviewed the bingo card containing Preservision Lutein with the 03/16/17 date and initials below the date. -The medication aides dated and initialed the medication cards when the first dose was administered from the card which hepled in determining if the medication was administered as ordered. Based on the number of capsules administered from the card (7) from 03/16/17 to 03/23/17 compared to the quantity remaining, she overlooked administering Resident #6's Preservision Lutein. (There were 23 tablets remaining and should have been 22 tablets remaining if administered during the morning medication pass). Continued interview on 03/23/17 at 10:45 am with the MA on 03/23/17 revealed: -The MA was not aware Resident #6 had not received all the medications scheduled for administration at 8:00 am on 03/23/17. -Resident #6 had gone to a doctor's appointment after her medications were administered and she had not administered Preservision Lutein to the resident before or after the medication pass. -She used the eMAR computer monitor combined with the bar code scanner to administer scheduled medications. -The bar code scanner had falsely approve a medication that was not scanned in the past; she did not know how or why. -She could not explain why the eMAR had documented the medication as administered when she had not scanned the bar code.	D 358		

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D 358	Continued From page 3 -Preservision Lutein did not appear as a medication that was missed during the morning medication pass. -She would notify the resident's physician's office and request an order to administer Resident #6's Preservision Lutein late. Interview on 03/23/17 at 10:55 am with the facility Nurse revealed: -She was the Resident Care Director (RCD) for the facility. -She managed medication aides and was responsible for assuring medications were administered as ordered. -She had contacted the pharmacy today (03/23/17) for an explanation as to why Resident #6's Preservision Lutein documented administration on the eMAR if the MA had not scanned the bar code, but the pharmacy had no explanation (they would research the issue). -Medications not scanned by the bar code system or approved by the MA should show up on a missed medication screen one hour after medications were not documented as administered. -Since the Preservision Lutein did not show up on the missed medication screen, (since it was documented as administered on the eMAR), the MA would not know she overlooked the medication during the medication pass. Interview on 03/23/17 at 3:20 pm with Resident #6 revealed: -She was ordered the vitamin to help her eyes (Preservision Lutein) due to declining vision. Her eye doctor thought it might help. -She routinely counted how many medications she received each morning, but she did not count the medications this morning because she was rushing for doctor's appointment.	D 358		

Division of Health Service Regulation

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D 358	Continued From page 4 -She depended on the medication aides to administer her medications as the doctor had ordered. B. Review of Resident #7's current FL-2 dated 10/20/16 revealed: -Diagnoses included hypertension, depression, anxiety, history of transient ischemic attack (stroke), and hyperlipidemia. -An order for omeprazole every morning. (Omeprazole is used to treat increased stomach acid, stomach ulcers, and acid indigestion.) Review of Resident #7's record revealed sign physician's orders dated 12/28/16 for omeprazole every morning. Observation of the morning medication pass on 03/23/17 at 8:55 am revealed: -The day shift medication aide (MA) prepared 8 oral medications for administration to Resident #7. -The MA reviewed the scheduled medications displayed on the monitor for the eMAR computer. -The MA used the bar code scanner and the medication packaging (bingo cards) to prepare Resident #7's medications for administration. -The count for the number of medications (8) prepared from the medication cards were verified with the MA prior to administration -The MA administered the medications, along with 4 ounces of water, to Resident #7 in the resident's room. -Omeprazole 20 mg was not included in the medications administered to Resident #7. Review of Resident #7's record revealed no subsequent physician's order to discontinue omeprazole 20 mg.	D 358		

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D 358	Continued From page 5 Review of Resident #7's electronic Medication Administration Record (eMAR) on 03/23/17 at 9:40 am revealed: -An entry for omeprazole 20 mg and scheduled for administration at 7:30 am daily. -Omeprazole was not documented as administered at 7:30 am on 03/23/17, as evidenced by the symbol (confirmed with the MA) used to document "not administered" located in the block for documenting administration. Observation on 03/23/27 at 10:45 am of medication on hand for administration for Resident #7 revealed: -A bingo card labeled omeprazole 20 mg dispensed on 02/27/17 for a quantity of 30 capsules. -Sixteen capsules remained in sealed bubble slots. -The card had a date of 03/09/17 and initials on the left side of the card. Interview on 03/23/17 at 10:40 am with the day shift MA revealed: -She administered Resident #7's medication at 9:00 am on 03/23/17. -She reviewed the bingo card containing omeprazole 20 mg with the 03/09/17 date and initials below the date. -The medication aides dated and initialed the medication cards when the first dose was administered from the card which helped in determining if the medication was administered as ordered. Based on the number of capsules administered from the card (14) from 03/09/17 to 03/23/17 compared to the quantity remaining, Resident #7 had not received omeprazole 20 mg on 03/23/17. (There were 16 tablets remaining and should	D 358		

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D 358	Continued From page 6 have been 15 tablets remaining if administered during the morning medication pass). Continued interview on 03/23/17 at 10:40 am with the day shift MA revealed: -The MA was not aware Resident #7 had not received omeprazole 20 mg scheduled for 7:30 am. -Omeprazole 20 mg was routinely administered by the day shift MA. -She was running behind the regular time of administration. -She used the eMAR computer monitor combined with the bar code scanner to administer scheduled medications. -The MA stated medications started appearing on a resident's eMAR computer screen one hour before and remained on the screen until one after administration was scheduled. -Medications not administered during the one hour before or one hour after scheduled time of administration should show up on the bottom of the screen under a tab for missed medication. -The tab should be flashing to call the MA's attention to the medications for review. -Since omeprazole 20 mg was scheduled at 7:30 am and she did not administer the medications scheduled for 8:00 am until just before the one hour after cut off, omeprazole should have moved to the missed medication screen at 8:30 am and flash a warning to alert the MA. -She reviewed the missed medications screen and omeprazole was not listed on the screen. -She did not administer omeprazole 20 mg because it was not displaying for administration. -She would notify the facility's Nurse. Interview on 03/23/17 at 11:00 am with the facility Nurse revealed: -She was the Resident Care Director (RCD) for	D 358		