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	HAL034099	A. BUILDING: _____ B. WING _____	07/06/2018

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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 and a Complaint Investigation on July 2-3, 2018 and July 6, 2018. The Complaint Investigaton was initiated by the Forsyth County Department of Social Services on 07/13/18.	D 000		
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 A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision for 2 of 6 sampled residents (#1 and #4) who were disoriented and ambulatory resulting in repeated falls with injuries including a cervical vertebrae fracture (#4) and elopement from the Special Care Unit (SCU) (#1). The findings are: 1. Review of Resident #4's current FL2 dated 03/16/18 revealed: -Diagnoses included Alzheimer's disease, and L5 disk disease. -Resident #4 was ambulatory. -Resident #4 was constantly disoriented. Review of Resident #4's current care plan dated	D 270	The facility will ensure all staff will provide supervision of the residents in accordance with each resident's assessed needs, care plan and current symptoms. The facility will ensure all staff will be trained on the resident's current condition and specific needs to include medical condition, new treatments or procedures, personal care needs, fall precautions and other needs as identified or change in a resident's condition occurs. The Resident Care Director, Resident Care Coordinator, Garden Place Coordinator and/or other qualified Carillon representative will provide training to staff on resident specific needs upon hiring, during routine staff meetings and while services are being provided.	8/6/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Melissa M. Bowyer TITLE Executive Director (X6) DATE 8/16/18

Reviewed and Approved Keisha Banks 08/17/2018

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D 270	Continued From page 1 7/19/17 revealed Resident #4 needed supervision with ambulation for safety. Review of Resident #4's record revealed: -Falls were documented on 01/12/18, 01/22/18, and 01/25/18. -There was no documentation of any interventions initiated after each of the above mentioned falls. -There was an order for a one-fourth bed rail dated 03/06/17. Review of an Incident/Accident Report for Resident #4 dated 04/19/18 revealed: -Resident #4 fell in her room and hit her head while a Personal Care Aide (PCA) was getting her dressed. -Emergency Medical Services (EMS) was called to transport Resident #4 to the hospital. Review of Resident #4's Progress Notes revealed: -There was documentation Resident #4 fell in her room on 04/19/18. -There was documentation Resident #4 had a follow up physician's appointment scheduled for 04/24/18. -There was no documentation of any interventions initiated after Resident #4 fell on 04/19/18. Review of the facility Fall Intervention Protocol revealed: -If a resident had 2 or more falls in one week, 3 or more falls in 1 month, or 4 or more falls in 3 months, the resident was considered to be at level one in the fall intervention protocol. -Level two protocol should be implemented after two weeks if a resident continued to fall at the same rate as the previous two-week period and	D 270	The Resident Care Director, Executive Director and other qualified Carillon representatives will conduct random monitoring to ensure staff awareness and supervision of residents. Responsible Party: Executive Director, Resident Care Director, Resident Care Coordinator, Garden Place Coordinator	

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D 270	Continued From page 2 showed no sign that level one protocols were effective in decreasing falls; The resident experienced 2 or more falls during the two week evaluation period; or if the regional nurse determines at any time during the six-week level one monitoring period that and advance to level two was needed due to increased falls. -Level Three protocol should be implemented if the resident demonstrates no change in the pattern/trend of falls demonstrated to date; the resident has experienced two or more falls during the two week evaluation period; or if the regional nurse determined at any point during the six week level two monitoring period that an advance to level three was needed due to increased falls. -Effective Interventions should be documented in the progress notes. -If all possible measures to reduce falls have been exhausted, it may be necessary to determine if the resident, family and their physician wish to upgrade to a higher level of care that would ensure safety and/or restrain the resident to prevent falls or if resident was to remain in the assisted living setting. Review of an Incident/Accident Report for Resident #4 dated 5/11/18 revealed: -Resident #4 was found on the floor behind her bed. -The resident complained of her head hurting. -EMS was called to transport Resident #4 to the hospital. Review of Resident #4's hospital After Visit Summary dated 05/16/18 revealed: -Resident #4 was hospitalized from 05/11/18 to 05/14/18. -Diagnoses Included: Fall as the primary diagnosis and closed non-displaced fracture of posterior arch of first cervical vertebra.	D 270		

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D 270	Continued From page 3 Review of Resident #4's Progress Notes revealed: -Resident #4 fell behind her bed on 05/11/18. -There was documentation facility staff was notified by hospital staff Resident #4 had a "cracked vertebra and a collar would be placed on her neck." -There was no documentation of any intervention in the progress notes initiated after Resident #4 fell on 05/11/18 and returned from the hospital. Review of an Incident/Accident Report for Resident #4 dated 5/24/18 revealed: -Resident #4 lost her balance and fell while ambulating in the dining room. -Resident #4 did not hit her head or complain of any pain. -EMS was not called. Review of Resident #4's Progress Notes revealed: -Resident #4 fell on 05/24/18. -There was documentation an 8 hour post fall check was completed for Resident #4. -There was no documentation in the progress notes of any interventions initiated after Resident #4 fell on 05/24/18. Review of an Incident/Accident Report for Resident #4 dated 5/31/18 revealed: -Resident #4 had an unwitnessed fall. -No location was indicated and no injuries were documented. -EMS was not called. Review of Resident #4's Progress Notes revealed: -Resident #4 had an unwitnessed fall. -There was no documentation of any intervention	D 270		

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D 270	Continued From page 4 in the progress notes initiated after Resident #4 fell on 05/24/18. Review of a physician's order on 07/06/18 revealed an order for a bed alarm dated 6/28/18. Observation of Resident #4's room on 7/6/18 at 12:40 pm revealed: -Resident #4 had a one-fourth bed rail that extended to a half bed rail. -There was a bed alarm attached to Resident #4's mattress. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Interview with a first shift Medication Aide (MA)/Supervisor on 7/3/18 at 3:00 pm revealed: -When a resident had a fall, staff were to call 911, contact the resident's family, and get the resident's paperwork ready for EMS. -The falls were not a part of her initial training upon hire and she had not had any training on falls since she had been employed by the facility. -She knew Resident #4 was a fall risk and had witnessed Resident #4 fall once during her shift. Interview with the Regional Operations Director on 7/3/18 at 5:13 pm revealed: -After a fall, residents should be assessed by the MA or Supervisor and the resident's physician should be notified. -Residents should be checked on "more frequently" (frequently was not defined) after a fall. -The expectations were that residents were checked on more than every two hours, but there were no scheduled safety checks implemented. -Staff were trained on the post fall checklist	D 270		

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D 270	Continued From page 5 (Includes questions and instructions after a fall) and the 24-hour post fall check list (requires check off of yes and no questions and documentation in the resident's progress notes 8, 16, and 24 hours post fall for 24 hours). -If there was any indication that a resident hit their head, then EMS should be called. -He did not know what interventions were put in place for resident #4 after falling. Interview with a MA/PCA/Supervisor on 07/06/18 at 8:33 am revealed: -For any unobserved falls, the MA or Supervisor was expected to call 911. -The MA or Supervisor should check the resident's vital signs, complete an incident report, document in the 24 hour book, fax a report to the resident's physician, and contact the resident's family. -She checked on residents who fell every 30 minutes to 1 hour, but she had never been told she had to. -She knew that Resident #4 was a fall risk. -She did not know of any interventions put in place after recent falls for Resident #4 to prevent further falls. Interview with a MA/PCA on 07/06/18 at 9:05 am revealed: -Resident #4 was a fall risk. -She thought Resident #4 had 2 or 3 falls this year, 2018. -Resident #4 had a bed alarm and a bed rail, but she did not know of any other interventions in place to prevent falls. Interview with the Special Care Unit Coordinator (SCUC) on 07/06/18 at 9:19 am revealed: -Resident #4 resided in the SCU and was a fall risk.	D 270		

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D 270	Continued From page 6 -When a resident fell, vital signs were checked. The resident was not to be moved or left alone. -If there was an unwitnessed fall or if a resident hit their head, staff was to call 911. -The MA checked the resident's vital signs, called the family, sent a report to the physician, and provided 24 hour documentation after each fall. -Staff tried to keep residents who fell in the common area to help prevent further falls. -Resident #4 fractured her neck after falling off of her bed. -She did not know of any specific interventions put in place for Resident #4 after her most recent falls. Interview with Resident #4's family member on 07/06/18 at 10:53 am revealed: -Resident #4 fell 2 or 3 times this year, but he did not know of any interventions in place for Resident #4 to prevent further falls. -"They seem to pay more attention to people who were not falling than to people who are falling." -"They don't check on her or bring her to the common area." -The facility staff asked him to purchase a bed rail last year to keep Resident #4 from falling out of bed. -Resident #4 did not have any issues with falling when her room was by the nurse's station. -"They keep moving her room and that's when she started falling." -She fell on the side of her bed and had to wear a hard collar during the day and a soft collar when she went to bed. -She had physical therapy when she got the bed rails last year. -There had not been any physical therapy order after any of Resident #4's other falls. Interview with a physical therapist on 07/06/18 at	D 270		

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D 270	Continued From page 7 11:31 am revealed: -The home health agency she works for received a referral for a home health assessment for physical therapy and occupational therapy on 07/05/18. -She was at the facility today to complete an initial assessment for physical therapy. -Resident #4 was scheduled for physical therapy visits 1 time a week for mobility. Interview with a Regional Nurse on 07/06/18 at 1:50 pm revealed: -She followed residents for 6 months after a fall if they met the requirements. -She may not physically lay eyes on the resident but followed them through stand up meetings. -Interventions were on-going and were up to the doctor to decide. -The facility staff worked with the physician to determine the best plan to prevent further falls. Interview with the Resident Care Director (RCD) on 07/06/18 at 1:55 pm revealed -Resident #4 was a fall risk and fractured her neck as a result of a fall. -Physical therapy and occupational therapy evaluations were requested for Resident #4 this week. -Resident #4 was not referred to physical therapy and occupational therapy prior to his week because the physician was making adjustments to her medication. -Standard safety checks for residents were every 2 hours. -If a resident fell, checks were performed "more than every 2 hours." -There were no scheduled increased safety checks implemented for residents who had a fall other than the 24 hour post fall checklist. -Resident #4 was just put on the fall protocol	D 270		

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D 270	Continued From page 8 where she would be followed by a Regional Nurse for 6 months. -The Regional Nurse would see the resident about once a month when she visited the facility. Interview with the Executive Director on 07/06/18 at 2:52 pm revealed: -When a resident fell, it was documented in the 24 hour notebook and discussed at the facility staff's stand up meeting the following day. -Staff should be documenting every 8 hours according to the 24 hour post fall checklist. -If a resident was on the fall protocol where the Regional Nurse would follow a resident for 6 months, documentation should be in the resident's record. -Post fall interventions were discussed for residents who fell, but she did not know if any had be initiated. -Physical therapy was ordered for Resident #4 this week, but she should have been referred to physical therapy months ago. Attempted telephone interview with Resident #4's current Primary Care Phyciain (PCP) on 7/3/18 at 11:27 am and on 7/6/18 at 10:41 am was unsuccessful. Interview with Resident #4's former primary care physician on 07/06/18 at 3:39 pm revealed: -He had requested for the facility physician to take over responsibility for Resident #4's care because it was too difficult to assess Resident #4 in his office. -Resident #4 had numerous falls. -The facility staffed faxed notification to his office regarding Resident #4's falls. -He had not ordered any interventions to prevent further falls. -Resident #4's last visit to his office was on	D 270		

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D 270	Continued From page 9 5/23/18 and she was seen by a physician's assistant who wrote orders for Resident #4 to continue wearing the hard collar during the day. -He personally last saw Resident #4 in January 2018. The Administrator was not available for interview on 07/02/03, 07/03/18, or 07/06/18. 2. Review of Resident #1's current FL2 dated 04/23/18 revealed: -Diagnoses included Alzheimer's dementia, hypertension, hyperlipidemia, and heart disease. Review of Resident #1's Personal Care and Physician authorization and Care Plan dated 04/23/18 revealed due to reside in a secure living environment. -Resident #1 needed extensive assistance with bathing, dressing, and grooming. Interview on 06/29/18 at 4:20 pm with Resident #1's family member revealed: -Resident #1 had Alzheimer's dementia and needed to be in a secured SCU. -The resident continually wandered throughout the SCU. -Resident #1 sometimes wandered in and out of other residents' rooms. -The family member visited Resident #1 on 06/10/18 and no facility staff told the family member the resident had eloped on 06/09/18. -On the evening of 06/11/18, the Resident Care Coordinator (RCC) called to tell the family member Resident #1 had eloped on 06/09/18. -The family member was very upset and concerned because it appeared the facility staff was always short of staff on the weekends. -The facility staff failed to immediately share incidents like the elopement with the family	D 270		

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D 270	Continued From page 10 member. Interview on 07/02/18 at 11:02 am with the dietary aide that found Resident #1 on 06/09/18 at the back parking lot revealed: -Resident #1 eloped during the end of first shift and the beginning of the second shift. -He went outside on break to smoke and it was about 3:15 pm. -He noticed Resident #1 was standing in the parking lot by the cars. -He knew Resident #1 resided in the SCU. -He notified the supervisor on duty that the resident was outside. -This was the first time he had seen a resident from the SCU outside. -He went to the SCU to check the gate/door and found there were two more residents sitting outside on the patio and no staff was with them. -The SCU patio was located outside the building, surrounded by the fence. -The fence that surrounded the SCU patio had a gate/door and when opened an alarm should sound to staff pagers. Interviews on 07/03/18 at 9:05 am and 11:00 am with the medication aide/supervisor (MA) revealed: -She supervised both the SCU and the assisted living unit. -She was the supervisor on duty when Resident #1 got out of the SCU on 06/09/18. -All supervisors in the facility had pagers. -The pagers showed the resident room number and the exact location of the resident when the pager alarmed. -All the doors and the gate/door to the fence around the SCU patio had alarms. -A supervisor could clear an alarm on their pager, but the alarm would continue to sound until	D 270		

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D 270	Continued From page 11 someone physically went to the alarm and pushed the reset button. -The day that Resident #1 got out of the facility "pagers had been going off all day." -She recalled seeing the alarm sound indicating the patio door in the SCU had been opened, but did not recall seeing the alarm sound to show the gate/door to the patio had been opened. -It was the facility's protocol when an alarm was alerted on the pager, staff were to go and check out why the alarm was activated. -An alarm activated to a SCU door required immediate response by staff to ensure no residents eloped. -She did not know why staff did not respond to the pager alarm when Resident #1 eloped on 06/09/18. -She was in the assisted living unit when a staff from the kitchen was outside in the back parking lot and observed Resident #1 outside near the parked cars. -The staff came back inside and told her. -She went outside and got Resident #1 back into the SCU. -She did not know how long Resident #1 was outside, but it was hot on Saturday, 06/09/18. -She estimated based on the warmth of Resident #1's skin the resident had been outside for close to 30 minutes. -She assessed the resident but did not notify the family member because she had never had that happen before and did not know what to do. -She did not know the facility's elopement or missing person policy. -This situation had never happened to her before, so she called the RCC to find out what she should do. -The RCC instructed her to contact the Executive Director. -The Executive Director told her to complete an	D 270		

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D 270	Continued From page 12 incident report. -She did not notify Resident #1's family member or physician, because she did not know what to do. -She left the incident report for the RCC, and on 06/11/18, the Executive Director told "them" what to do. Interview on 07/03/18 at 12:00 pm with the RCC revealed: -Prior to Resident #1's elopement on 06/09/18, the facility had never had a resident to elope. -She instructed the MA to contact the Executive Director and maintenance person. -She did not know the facility's elopement policy instructed to contact the physician and family member immediately. -On 06/11/18, the Executive Director instructed her to notify Resident #1's family member. Interview on 07/03/18 at 3:08 pm with a second MA revealed: -She was the MA on duty on the first shift on 06/09/18 when Resident #1 eloped. -She left a few minutes early and had already turned the pager over to the second shift MA. -If the patio door was disarmed with the alarm turned off, it would had to have been done by staff. -Prior to Resident #1's elopement, it was common for staff leave the SCU patio door unlock to allow residents to go out as they pleased. -She did not know the fence around the SCU patio had a gate/door or that there was an alarm on the gate/door. Interview on 07/03/18 at 6:21 pm with a third MA/PCA revealed: -He started working at the facility in March 2018, he started work as a PCA, then became a	D 270		

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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 270	Continued From page 13 medication aide. -He was the MA/supervisor in the SCU on the second shift when Resident #1 eloped on 06/09/18. -He recalled seeing Resident #1 when he first started "counting off medications" on 06/09/18 with the first shift MA. -He did not see Resident #1 again until she was found outside. -The supervisor in the assisted living unit informed him and the first shift MA that the dietary aide had seen Resident #1 outside in the back parking lot. -He went out through the SCU patio and observed two more residents outside sitting on the patio. -He did not know the residents were outside and did not see any staff outside with the residents. -The alarm to the patio door had been turned off. -A staff (MA or PCA) had to turn the alarm off, because a resident would not be able to maneuver the system. -What probably happened was a staff turned the alarm off so that residents were able to go out and come in as they pleased. -The first shift MA still had the pager and had not turned it over to him. -The alarm should have sounded to the pager, and the MA should have checked the gate/door. -The pagers could be silenced, so the MA would not hear the alarm, but the notification would still show up on the pager. Interview on 07/03/18 at 7:02 pm with the maintenance director revealed: -He was not on duty the day Resident #1 eloped. -He was called to the facility to ensure the lock and alarm to the fence gate/door and the patio door in the SCU worked properly. -He checked both and they worked properly.	D 270		

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	HAL034099	A. BUILDING: _____ B. WING _____	07/06/2018

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D 270	Continued From page 14 -He checked the alarm system panel to ensure it was operational, and working correctly. -The system showed the gate/door to the fence was opened at 2:58 pm and the alarm sounded to staff pager. -The alarm was not deactivated until 3:25 pm. -The alarm to the patio door was not activated when opened because it was already deactivated. -The patio door could have only been deactivated by a staff physically turning the alarm off. -Before he left the facility on 06/09/18 he made sure the system was set to alarm if the gate/door and patio door was opened. Interview on 07/06/18 at 3:28 pm with the Executive Director revealed: -The pagers alarmed for all locked doors. -Staff were required to check their pagers at all times and respond to all alarms. -The alarms for the SCU locked door required all staff to respond, not just SCU staff. -She expected staff not to disarm the SCU patio doors and not to leave residents on the patio unattended. -The next week after the incident, she retrained staff regarding the facility's policy and new policies were developed. Review of the facility's secured setting device training checklist revealed: -When a door that opens to an unsecured area in the SCU opens or closes, a page was sent to the nurse call system to alert that an "Intrusion" has occurred. The page will show the location of the door, such as C-hall end." -A page of a C-hall door intrusion must be treated as an emergency and required all staff who observed the page to respond to the designated location to determine why the intrusion occurred. -If there was no readily identifiable reason for the	D 270		

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D 270	Continued From page 15 intrusion, it should be assumed a resident had exited the building and the missing resident policy must be followed until all residents were accounted for. Based on observation and interviews it was determined that Resident #1 was not interviewable. Review of the facility's "Alzheimer and Dementia Diagnosis Differentiation and Placement Policy" regarding elopement revealed: -An elopement represented a serious situation that is dangerous to the safety and well being of the resident; if an elopement occurred the following steps should be taken. -Return the resident, keep the resident in sight at all times and keep the resident calm. -Notify the resident's family member and physician. -Request an immediate evaluation of the current behavior by the physician. -If the physician or family member can not be reached a team member is to remain with the resident at all times until the family or doctor can be reached. The facility failed to supervise confused, disoriented, and ambulatory residents who experienced multiple repeated falls resulting in vertebrae fracture (#4); and an elopement out of the SCU (#1). The facility's failure resulted in substantial risk for further physical harm to residents which constitutes a Type A2 Violation. The facility submitted a Plan of Protection in accordance with G.S. 131D-34 on 07/03/18. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 6,	D 270		

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D 270	Continued From page 16 2018.	D 270		
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 observation, record reviews and interviews the facility failed to ensure physician notification for 1 of 5 sampled residents (Resident #1) with swollen and red feet, ankles and legs, and complaint of leg pain. The findings are: Review of Resident #1's current FL2 dated 04/23/18, with diagnoses of Alzheimer's dementia, hypertension, hyperlipidemia, and heart disease. Observation on 07/03/18 at 11:00 am of Resident #1 revealed: -The resident was walking back and forth through the Special Care Unit (SCU). -The resident did not have shoes on, but had on blue/green socks with grips. -The resident had pants that were extended down to the rim/top of the socks. Observation on 07/03/18 at 4:50 pm of Resident #1 revealed:	D 273	The facility will ensure referral and follow-up to meet routine and acute healthcare needs of the residents. The Resident Care Director or other Carillon qualified representative will assess the resident upon report of any change of condition and noted changes will be communicated to the physician to ensure the proper referral and follow-up needed are completed. The facility will ensure all staff receives additional training on reporting resident needs, change in resident condition or other concerns. The facility will ensure the Resident Care Coordinator and Resident Care Director and Supervisor in Charge receive training on referral and follow-up expectations to include assessment, referral and follow-up with resident, physician, staff and the responsible party as required. The Executive Director, Resident Care Director and other qualified Carillon representatives will conduct random audits of resident records to ensure proper documentation of referral and follow-up has occurred. Responsible Party: Executive Director, Resident Care Director	8/20/18

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D 273	Continued From page 17 -Later that day, Resident #1 had on one blue/green sock with grips, and one light blue sock without grips. -Swelling was observed in both of the resident's feet and legs. -Due to the socks and the resident not wanting to sit down, the extent of the swelling could not be determined. Observation on 07/06/18 at 12:31 pm with of Resident #1's feet, ankles and lower legs below the knee revealed: -The resident had moderate edema to both the right and left legs. -The resident had redness on the lower left leg. -The resident said to the personal care aide assisting her, "my leg hurts." Review of a nurses' note for Resident #1 revealed: -At 07/04/18 at 7:09 pm, Resident #1's family member told the nurse Resident #1 had swelling in her right foot and leg. -The resident had 3 plus pitting edema. -The resident was sent to the emergency department. Interview on 07/05/18 at 8:21 am with Resident #1's family member revealed: -She visited Resident #1 last week (either 06/26/18 or 06/27/18) and noticed the resident was limping. -Resident #1 told the family member that her leg was hurting. -She looked at Resident #1's legs and noticed a bruise and reported it to the medication aide (MA) on duty. -The family member visited Resident #1 on 07/04/18 at 5:25 pm and checked Resident #1's legs to see if the bruise was still there.	D 273		

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D 273	Continued From page 18 -She noticed Resident #1's feet, ankle and legs were "horribly" swollen. -She told the MA and the facility nurse about the swollen legs, ankle and feet, and Resident #1 was sent to the emergency department. Interviews on 07/06/18 at 9:05 am and 1:38 pm with the Special Care Unit Coordinator (SCUC) revealed: -Sometime last year Resident #1 had cellulitis or some other problem with her left knee. -The resident had a standing order to elevate legs when her knee was bothering her, but nothing regarding the cellulitis. -She did not recall any medication orders regarding the cellulitis. -Staff did not mention to her that Resident #1 had swollen feet, ankles or legs or that staff had observed redness in the resident's leg. -It was the facility's protocol that personal care aides (PCAs) dressed residents in the morning and undressed residents for bed at night. -If a PCA had observed Resident #1's feet, ankle and legs were swollen they should have reported it to the MA on duty. -The MA would have called or faxed the resident's physician. -If the PCA did not know what to do she should at least have reported it to someone. -If there was contact with the resident's physician the documentation should be in the resident's record. -If there was no documentation, then the resident's physician had not been contacted. Review of notes in Resident #1's record revealed there was no documentation of the swelling or redness in Resident #1's legs, ankles and feet prior 07/04/18.	D 273		

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D 273	Continued From page 19 Review of the hospital report dated 07/04/18 revealed: -Resident #1 was diagnosed with cellulitis. -Physician's orders for an antibiotic and for the resident to wear shoes at all times when out of bed. According to the Mayo Clinic lower leg swelling can be caused by inflammation in leg tissues. The inflammation may be a normal response to injury or disease, and contribute to cellulitis, which includes symptoms of: skin redness, swelling, tenderness, warmth and pain. Interview on 07/06/18 at 12:42 pm with a MA revealed: -She was the supervisor of the SCU. -It there were problems or concerns with a resident the staff were to report the concerns to her. -She was responsible for reporting the concern to the appropriate person or health care professional. -No staff had reported to her they had observed redness and swelling in Resident #1's feet, ankles and legs. Interview on 07/06/18 at 2:49 pm with the PCA revealed: -This morning and the past three days she assisted Resident #1 with getting dressed. -She had noticed the resident's feet, ankles and legs were swollen. -She did not tell anyone because she did not know that she needed to report the swelling to anyone. -Resident #1's feet, ankles and legs were usually red, she thought it was because the resident walked a lot and usually did not have shoes on. -She had noticed the socks left an indention in	D 273		

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D 273	Continued From page 20 the resident's legs and ankles, but had not reported it to anyone. -The first month she worked at the facility Resident #1 wore shoes. -The second month the resident started to take her shoes off, and staff had to frequently put them back on. -Resident #1 told her that the shoes were hurting her feet. -She did not share that information with the SIC or any other staff at the facility. -The next month the resident was not wearing any shoes. Interview on 07/06/18 at 3:28 pm with the Executive Director revealed: -She worked on 07/04/18, and the Resident Care Director (RCD) told her that Resident #1 had swollen legs and feet, and was being sent to the emergency department. -Prior to that day no one had told her the resident had swollen legs and feet. -It was the facility's protocol if a PCA identified a resident had a healthcare issue or a resident told them of a problem, they were to notify the MA, which was the supervisor. -The MA was to notify the resident's physician. -There should be documentation in the resident's record that corresponded to the problem and how staff addressed the issue. Interview on 07/03/18 at 12:13 pm with the nurse at Resident #1's physician's office revealed: -The physician had not seen Resident #1 for cellulitis. -No one had notified the physician that Resident #1 had swelling and redness to her lower extremities. -No one had notified the physician the resident was not wearing shoes.	D 273		

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D 273	Continued From page 21 Based on observation and interviews it was determined that Resident #1 was not interviewable. Based on observation, record reviews and interviews the facility failed to notify the physician when a resident (Resident #1) had swollen and red legs, ankles and feet. The facility's failure was detrimental to the health of the resident which constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G. S. 131D-34 on 07/26/18. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 20, 2018.	D 273		8/20/18
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 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: Based on observations, record reviews and interviews, the facility failed to assure implementation of physician orders for 2 of 6 sampled residents (#4 and #6) for a hard cervical collar to be worn during the day time and a soft	D 276	The facility will ensure all physician's orders, written procedures, treatments or other orders from an health care professional as well as implementation of procedures, treatments or orders as specified in Subparagraph (c)(3) of this rule are documented in the resident record. All physician orders will be verified to ensure implementation of all treatments, procedures or other orders as directed. The facility will ensure all staff will be trained on the resident's specific needs to include changes in medical condition and any related physician orders, treatments or procedures to be implemented to address a resident's condition.	

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D 276	Continued From page 22 cervical collar to be worn at bedtime (Resident #4) and a hard cervical collar to be worn at all times except when bathing and receiving assistance with hygiene (Resident #6). The findings are: 1. Review of Resident #4's current FL-2 dated 03/16/18 revealed: -Diagnoses included Alzheimer's disease and L5 Disk Disease. -Resident #4 was constantly disoriented. Review of Resident #4's hospital After Visit Summary dated 04/16/18 revealed: -Resident #4 was hospitalized from 05/11/18 to 05/14/18. -Diagnoses included: Fall as the primary diagnosis and closed non-displaced fracture of the posterior arch of first cervical vertebra. -There were instructions for Resident #4 to wear the soft cervical collar when in bed or eating and to wear the hard collar when out of bed. Review of a subsequent physician's order dated 06/28/18 for Resident #4 revealed the hard collar was to be worn during the day time and the soft collar was to be worn overnight. Observations in the Special Care Unit (SCU) on 07/02/18 at 10:45 am and 3:30 pm revealed Resident #4 was wearing the soft cervical collar instead of the hard collar. Review of the electronic Medication Administration Records (eMAR) for May and June 2018 revealed: -There was an entry for the hard collar to be worn during the day. -It was documented the hard collar was applied	D 276	The Executive Director, Resident Care Director and other qualified Carillon representatives will conduct random audits of resident records to ensure proper implementation of this rule. Responsible Party: Executive Director, Resident Care Director	

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D 276	Continued From page 23 on 05/31/18 and 06/01/18 to 06/30/18. -There was an entry for the soft collar to be worn over night. -It was documented the soft collar was applied at 8:00 pm on 05/30/18, 05/31/18 and 06/01/18 to 06/30/18. Interview with a Medication Aide (MA)/Supervisor on 07/03/18 at 3:00 pm revealed: -Resident #4 was supposed to wear a hard collar during the day and a soft collar at night. -Resident #4 used to have an order to wear the soft collar when she ate her meals, but wearing the soft collar during her meals was no longer a part of the order for the collar. -She was working as a MA on 07/02/18, when the resident was observed wearing the soft collar during the day. -She thought she had put the hard collar on Resident #4. Interview with a second shift MA/Supervisor on 07/03/18 at 6:19 pm revealed: -Resident #4 wore the hard collar during the day and the soft collar at night when she went to bed. -The MA/Supervisor was responsible for making sure the hard collar was on Resident #4 during the day because the MA/Supervisor would be the one documenting that it had been applied. -He had seen Resident #4 wearing the soft collar during the day, but he did not know the resident was supposed to wear a hard collar during the day at that time. -Resident #4 was not able to take off or put on her own collar. Interview with a MA/Supervisor/Personal Care Aide (PCA) on 07/06/18 at 8:33 am revealed: -Resident #4 was to wear the hard neck collar when up and walking and the soft collar when	D 276		

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D 276	Continued From page 24 laying down. -She had never seen Resident #4 with a soft collar on during the day. -She never knew Resident #4 to refuse to put the hard collar on. Interview with a MA/PCA on 07/06/18 at 9:05 am revealed: -Resident #4 injured herself after rolling off her bed and came back from the hospital with a neck brace. -Resident #4 was to wear the hard collar during the day and the soft collar at night. Interview with the Special Care Unit Coordinator (SCUC) on 07/06/18 at 9:19 am revealed: -Resident #4 fractured her neck after falling off of her bed. -Resident #4 wore the soft collar to sleep in and the hard collar when awake. -She did not know Resident #4 had on a hard collar for most of the day on Monday, 07/02/18. -The MA/Supervisor was responsible for making sure Resident #4 had her collar on. Interview with Resident #4's family member on 07/06/18 at 10:53 pm revealed: -She fell on the side of her bed and had to wear a hard collar during the day and a soft collar when she went to bed. -Resident #4 had a collar on during the times when he visited. Interview with a PCA on 07/06/18 at 11:41 am revealed: -Resident #4 wore a neck collar because of falls was what she was told. -Resident #4 was supposed to wear the hard collar during the day and the soft collar was supposed to be worn at night.	D 276		

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D 276	Continued From page 25 -She had observed Resident #4 wearing the soft collar during the day several times within the last month, but she did not know Resident #4 should have been wearing a hard collar at the time. -The MA/Supervisor was responsible for making sure Resident #4 was wearing the correct collar at the correct time. Interview with the Resident Care Director (RCD) on 07/06/18 at 1:55 pm revealed: -She was responsible for overseeing resident care in the assisted living unit and in the SCU. -Resident #4 had a spine fracture that resulted from a fall. -Resident #4 was to wear the hard collar during the day and the soft collar at night. -She had observed Resident #4 wearing the soft collar during the day once and went to get a MA to put the hard collar on. -She became aware on Tuesday, 07/02/18, that Resident #4 had the soft collar on for most of the day on Monday, 07/03/18. -The MA and Supervisor were responsible for putting the hard collar on during the day and the soft collar on at night. -The PCAs were responsible for letting the MA or Supervisor know if the collar was not on. Interview with the Executive Director on 07/06/18 at 2:52 pm revealed: -Resident #4 had a hard neck collar which she wore in the daytime and a soft collar which she wore only at night. -She had been wearing the neck collar since May 2018 after a fall in the facility. -The Supervisor, MA, and SCUC were responsible for making sure Resident #4 had her hard and soft collars on at the appropriate times. -She expected for Resident #4 to have the hard collar on in the daytime and the soft collar on at	D 276		

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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 276	Continued From page 26 night. Interview with Resident #4's former primary care physician (PCP) on 07/06/18 at 3:39 pm revealed: -He did not order the neck collar and did not know anything about it. -The order for the neck collar came from the hospital. -Resident #4's last visit to his office was on 5/23/18 and she was seen by a physician's assistant who wrote orders for Resident #4 to continue wearing the hard collar during the day. Attempted telephone interview with Resident #4's current PCP on 7/3/18 at 11:27 am and on 7/6/18 at 10:41 am was unsuccessful. The Administrator was not available for interview on 07/02/03, 07/03/18, or 07/06/18. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. 2. Review of Resident #6's current FL-2 dated 06/20/18 revealed: -Diagnoses included unspecified non-displaced fracture of 2nd cervical vertebrae and unspecified dementia without behavioral disturbance. -Resident #4 was constantly disoriented. Review of Resident #6's hospital discharge summary dated 06/01/18 revealed: -Resident #6 was admitted to the hospital on 05/30/18 and discharged on 06/01/18. -The admitting and discharge diagnosis was odontoid fracture with type III morphology and routine healing. -There were instructions for Resident #6 to wear	D 276		

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D 276	Continued From page 27 the hard neck collar. Review of discharge treatments from a skilled nursing facility dated 06/21/18 revealed Keep cervical collar on at all times. Review of a verbal order dated 06/22/18 revealed Remove Aspen (hard) Collar for bathing and hygiene only then collar to be reapplied. Review of physician's orders dated 06/28/18 revealed "Remove collar for bathing and hygiene only then reapply." Review of physical therapy documentation dated 07/02/18 revealed: -"Client" was not wearing cervical collar upon arrival. -"Reinforced use/importance to client/ALF staff." Review of Resident #6's electronic Medication Administration Records (eMAR) for June 2018 revealed: -There was an entry to document on first, second, and third shifts to remove neck collar for bathing and hygiene only then reapply. -It was documented Resident #6 refused to wear the collar 4 out of 9 times from 06/22/18 to 06/30/18 during third shift. Review of Resident #6's eMAR for July 2018 revealed: -There was an entry to document on first, second, and third shifts to remove neck collar for bathing and hygiene only then reapply; MA/Supervisor to reapply collar if "patient" removes it. It is to be worn at all times. -Documentation on 07/02/18 that the collar for Resident #6 had been applied during first, second, and third shifts.	D 276		

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D 276	Continued From page 28 -Documentation on 07/03/18 that the collar for Resident #6 had been applied during first and second shifts, but there was no documentation the collar had been applied during third shift. Observation of the Resident #6 on 07/02/18 at 10:45 am revealed Resident #6 was not wearing a collar. Observation of the Resident #6 in the SCU on 07/03/18 at 10:30 am revealed: -Resident #6 was not wearing a collar. -Resident #6's head was leaning to the right side and her neck appeared stiff when she turned to look to the right. Interview with Resident #6 on 07/03/18 at 10:35 am revealed: -She fell somewhere and hurt her neck and was supposed to wear a hard collar. -She did not have her hard collar on and did not know where the hard collar was. -"They want me to wear it (the collar) all the time." -"It (her neck) hurts right now." Interview with a Medication Aide (MA)/Supervisor on 07/03/18 at 3:00 pm revealed: -Resident #6 wore a hard neck collar during the day and also slept in it. -She was made aware by a PCA Resident #6's hard neck collar was not in her room. -She was not wearing the neck collar because staff could not find it. -The neck collar was found on top of the refrigerator and applied to Resident #6's neck. -Resident #6 fell at the facility, was gone for about a month, and returned with the neck collar. Interview with a Personal Care Aide (PCA) on 07/03/18 at 6:10 pm revealed:	D 276		

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D 276	Continued From page 29 -Resident #6's hard collar was put on after dinner. -She was told by a Supervisor that Resident #6 was not required to keep the hard collar on all the time. -She was told by the Executive Director (ED) on today, 07/03/18, that Resident #6 should have the neck collar on at all times. -Resident #6 was able to take her neck collar off, but she had never observed her doing so. Interview with a second shift MA/Supervisor on 07/03/18 at 6:19 pm revealed: -He thought Resident #6 was supposed to keep the hard collar on during the daytime and remove before she went to bed. -He did not know Resident #6's collar was supposed to be removed only for bathing and hygiene and then reapplied. -Resident #6's collar was taken off during meals. -Resident #6 was able to remove her hard collar. Interview with a MA/Supervisor/PCA on 07/06/18 at 8:33 am revealed: -She worked first shift on 07/03/18. -Resident #6 was not wearing her hard collar on the morning of 07/03/18 and she did not know why. -Resident #6 sometimes took off her hard collar, but staff were able to put the collar back on without difficulty. -The Supervisor and MA were responsible for making sure the hard collar was on Resident #6 at all times. Interview with the SCUC on 07/06/18 at 9:19 am revealed: -Resident #6 should wear the hard collar at all times. -Resident #6 was able to take her collar off and she liked to hide it in her room.	D 276		

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D 276	Continued From page 30 -The PCAs should let the MA know if Resident #6's collar was not on. Interview with another PCA on 07/06/18 at 11:41 am revealed: -Resident #6 was supposed to wear the hard collar all the time. -The MA/Supervisor was responsible for making sure Resident #6 was wearing her collar. Interview with Resident #6's family member on 07/06/18 at 12:04 pm revealed Resident #6 was supposed to wear the hard collar 24 hours a day except when she took showers. Interview with the Resident Care Director (RCD) on 07/06/18 at 1:55 pm revealed: -She was responsible for overseeing resident care in assisted living and in the SCU. -Resident #6 should wear the hard collar all the time. -She had never seen Resident #6 without her hard collar and was not aware that Resident #6 did not have her hard collar on the mornings of 07/02/18 and 07/03/18. Interview with the Executive Director on 07/06/18 at 2:52 pm revealed: -Resident #6 had a physician's order to wear a hard collar. -Resident #6 was able to take the hard collar off, but she expected the MA and Supervisor to put the collar back on if she took it off. -She expected Resident #6 to wear the hard collar all the time. Attempted telephone interview with Resident #6's PCP on 7/3/18 at 11:27 am and on 7/6/18 at 10:41 am was unsuccessful.	D 276		

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D 309	Continued From page 31	D 309		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets In Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with 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 ensure an accurate and current listing of residents with physician-ordered therapeutic diets was available for guidance of food service staff for 1 of 6 residents sampled (#4). The findings are: Review of Resident #4's current FL2 dated 03/16/18 revealed: -Diagnoses included Alzheimer's disease and L5 disk disease. -There was a physician's order for a regular diet. Review of a subsequent physician's order dated 05/31/18 revealed there was a physician's order for a mechanical soft diet and finger foods. Review of the therapeutic diet list posted in the kitchen on 07/02/18 revealed Resident #6 was to receive a regular diet. Observation of the breakfast meal service on 07/03/18 at 8:00 am revealed: -Resident #4 was served scrambled eggs, bacon, toast, and oatmeal. -Resident consumed 100% of the meal.	D 309	The facility will ensure an accurate and current listing of resident with physician-ordered therapeutic diets for guidance of food service staff. All physician orders including therapeutic diets will be verified upon receipt and updated on the dietary tracking form for to ensure guidance to kitchen staff and personal care staff for proper implementation. All kitchen staff and personal care staff will receive additional training on the dietary tracker and implementation of therapeutic diets. The Executive Director, Resident Care Director and other qualified Carillon representatives will conduct random audits of the resident records to ensure proper implementation of this rule. Responsible Party: Executive Director, Resident Care Director, Dietary Services Director	8/20/18

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D 309	Continued From page 32 Observation of the lunch meal service on 07/06/18 at 12:11 pm revealed: -Resident #4 was served fish, rice, beets, hush puppies, desert of choice, 2% milk, tea, and water. -Resident consumed 75% of the meal. Interview with the Dietary Manager (DM) on 07/02/18 at 3:30 pm revealed: -The Resident Care Coordinator (RCC) and the Resident Care Director (RCD) were responsible for updating the therapeutic diet list. -Residents were served according to the therapeutic diet list. -She received an updated diet list when diet orders changed and when new residents were admitted to the facility. Interview with the Special Care Unit Coordinator (SCUC) on 07/06/18 at 9:19 am revealed: -Resident #4 was on a regular diet. -There was a therapeutic diet list in the SCU dining room which had Resident #4 listed to be served a regular diet. -The RCD and the RCC were responsible for making sure that the diet order matched the therapeutic diet list and for updating the therapeutic diet list. -The therapeutic diet list was updated at least twice a month and when new residents moved in. -The physician wanted Resident #4 to eat finger foods, but never wrote an order for finger foods or a mechanical soft diet to her knowledge. -She did not know there was a current order for finger foods. Interview with the Resident Care Director (RCD) on 07/06/18 at 1:55 pm revealed: -She was responsible for updating the therapeutic	D 309		

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D 309	Continued From page 33 diet list. -The diet list was updated quarterly. -The RCD checked the therapeutic diet list weekly and printed a copy off for the kitchen and for the SCU. -Resident #4 was on a regular diet and had not been ordered any other diet that she was aware of. -She did not know there was a physician's order for a mechanical soft diet and finger foods. -She did not know that Resident #4's diet order did not match the therapeutic diet list. Interview with the Executive Director on 07/06/18 at 2:52 pm revealed: -She did not know what diet Resident #4 was on without looking at the therapeutic diet list. -The RCD was responsible for reviewing and clarifying diet orders and updating the therapeutic diet list. -The RCD provided the kitchen and SCU with updated therapeutic diet list. -She did not know that Resident #4's most recent physician's order was for a mechanical soft diet and finger foods. -She was not sure what therapeutic diets were served at the facility. -She expected for Resident #4's diet to be served as ordered or for her diet to be clarified. Interview with Resident #4's former primary care physician (PCP) on 07/06/18 at 3:39 pm revealed Resident #4 was on a regular diet the last time she was seen in his office. Interview with the RCC on 07/06/18 at 3:58 pm revealed: -The RCD and the RCC were responsible for updating and clarifying diet orders. -The RCD was responsible for updating the diet	D 309		

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D 309	Continued From page 34 tracker (diet list) which were printed "every couple days." -Copies of the diet list were given to the kitchen and to the SCU. -The RCD checked the diet list weekly. -The facility served regular, ground meat, and no concentrated sweets diets. -Resident #4 was on ground meats but it was hard to eat so she did better with finger foods. -There was not a diet order for finger foods; "It was just better for Resident #4." -She did not know Resident #4 had a physician's order for a mechanical soft diet and finger foods. -She did not know the diet order did not match the therapeutic diet list. Interview with a MA/PCA on 07/06/18 at 4:37 pm revealed: -She knew Resident #4 was on regular diet because she reviewed the therapeutic diet list. -She was did not know of any changes in Resident #4's diet. Attempted telephone interview with Resident #4's current PCP on 7/3/18 at 11:27 am and on 7/6/18 at 10:41 am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	D 309		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310	The facility will ensure all therapeutic diets including nutritional supplements and thickened liquids are prepared and served as ordered by the resident's physician.	8/20/18

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D 310	Continued From page 35 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 6 residents (#4) sampled with physician's orders for a Mechanical Soft diet and finger foods was served as ordered. The findings are: Review of Resident #4's current FL2 dated 03/16/18 revealed: -Diagnoses included Alzheimer's disease and L5 disk disease. -There was a physician's order for a regular diet. Review of a subsequent physician's order dated 05/31/18 revealed there was a physician's order for a mechanical soft diet and finger foods. Review of the therapeutic diet list posted in the kitchen revealed Resident #3 was to be served a regular diet. Review of the therapeutic diet menus revealed there was not a mechanical soft or finger foods menu available. Review of the regular breakfast menu for 07/03/18 revealed residents were to be served hot or cold cereal, eggs, bread, bacon or sausage, margarine/jam, assorted juices, water, 2% milk, coffee and tea. Observation of the breakfast meal service on 07/03/18 at 8:00 am revealed Resident #4 was served scrambled eggs, bacon, toast, and oatmeal.	D 310	All physician orders including therapeutic diets will be verified upon receipt and updated on the dietary tracking form to ensure guidance to kitchen staff and personal care staff for proper implementation. All kitchen staff and personal care staff will receive additional training on the dietary tracker and implementation of therapeutic diets. The Executive Director, Resident Care Director and other qualified Carillon representatives will conduct random audits of the resident records to ensure proper implementation of this rule. Responsible Party: Executive Director, Resident Care Director, Dietary Services Director	

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D 310	Continued From page 36	D 310		

It could not be determined if Resident #4 was served the appropriate meal due to no mechanical soft or finger food menu available for staff guidance.

Review of the regular lunch menu for 07/06/18 revealed residents were to be served Friday's seafood selection, steamed rice, beets, baked hush puppies, margarine, desert of choice, 2% milk, coffee, tea and water

Observation of the lunch meal service on 07/06/18 at 12:11 pm revealed:
-Resident #4 was served fish, rice, beets, hush puppies, desert of choice, 2% milk, tea, and water.
-Resident #4 had a knife, spoon, and fork available in her table service.
-Resident consumed 75% of the meal.

It could not be determined if Resident #4 was served the appropriate meal due to no mechanical soft or finger food menu available for staff guidance.

Interview with the Dietary Manager (DM) on 06/02/18 at 3:30 pm revealed:
-Residents were served meals according to the therapeutic diet list.
-The Resident Care Coordinator (RCC) and the Resident Care Director (RCD) were responsible for updating the therapeutic diet list for staff guidance in food service.

Interview with a first shift Medication Aide (MA)/Supervisor/Personal Care Aide (PCA) on 07/06/18 at 8:33 am revealed Resident #4 was on a regular diet and had always been on a regular

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D 310	Continued From page 37 diet as far as she knew. Interview with the Special Care Unit Coordinator (SCUC) on 07/06/18 at 9:19 am revealed: -Resident #4 was on a regular diet. -There was a therapeutic diet list in the SCU dining room which listed Resident #4 was to be served a regular diet. -The physician wanted Resident #4 to eat finger foods, but never wrote an order for finger foods or a mechanical soft diet to her knowledge. Interview with the RCD on 07/06/18 at 1:55 pm revealed: -The facility offered regular, ground, chopped, and blended diets -Resident #4 was on a regular diet and had not been ordered any other diet that she was aware of. -She did not know there was a physician's order for a mechanical soft diet and finger foods. -The RCC signed off on the diet order for a mechanical soft diet and finger foods. -The RCC or the RCD should have clarified the diet order with the physician because the facility did not offer a mechanical soft diet. Interview with the Executive Director on 07/06/18 at 2:52 pm revealed: -She was not sure what therapeutic diets were served at the facility. -She did not know what diet Resident #4 was on without looking at the therapeutic diet list. -She did not know Resident #4's most recent diet order was for a mechanical soft diet and finger foods. -She expected for Resident #4's diet to be served as ordered. Interview with the RCC on 07/06/18 at 3:58 pm	D 310		

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D 310	Continued From page 38 revealed: -The RCD and the RCC were responsible for updating and clarifying diet orders. -Resident #4 was on ground meats but it was hard to eat so she did better with finger foods. -"There was not a diet order for finger foods; it was just better for Resident #4." -She did not know Resident #4 had a physician's order for a mechanical soft diet and finger foods. -The diet order should have been clarified because the facility did not offer a mechanical soft diet. -She signed off on the diet order. -She knew about the finger foods, but not the order for a mechanical soft diet. -She missed the order for a mechanical soft diet. Attempted telephone interview with Resident #4's current PCP on 7/3/18 at 11:27 am and on 7/6/18 at 10:41 am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	D 310		
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.	D 358	The facility will ensure that the preparation and administration of medications, prescription and non-prescription are in accordance with the orders by a licensed prescribing practitioner which are maintained in the resident's record and the rules in this section as well as the facilities policies and procedures.	8/20/18

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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 358	Continued From page 39 This Rule Is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 6 sampled residents (Resident #4) with a physician's order for Ativan (used to treat anxiety). The findings are: Review of Resident #4's current FL2 dated 03/16/18 revealed: -Diagnoses included Alzheimer's disease and L5 Disk Disease. -There was a physician's order for Ativan 0.05 mg, 3 times daily with meals. Review of the Resident #4's hospital After Visit Summary dated 05/16/18 revealed: -Resident #4 was hospitalized from 05/11/18 to 05/14/18. -The order for Ativan 0.05 mg had changed from 3 times daily with meals to 0.05 mg every 8 hours as needed for anxiety. Review of Resident #4's May 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Ativan 0.05 mg, 1 tablet daily with meals scheduled at 8:00 am, 12:00 pm, and 8:00 pm. -Ativan was documented as administered at 8:00 am, 12:00 pm, and 8:00 pm from 05/01/18 to 05/10/18, at 12:00 pm and 8:00 pm on 05/14/18, and from 05/15/18 to 05/31/18. -There was not an entry for Ativan 0.05 mg every 8 hours as needed for anxiety. Review of Resident #4's June 2018 eMAR	D 358	The Resident Care Director, Resident Care Coordinator or other qualified Carillon representative will verify all medications upon receipt of orders from the licensed practitioner. The Resident Care Director, Resident Care Coordinator, Medication Technicians will receive additional training on the medication clarification and verification process upon receipt of new orders. The Executive Director, Resident Care Director and other qualified Carillon representatives will conduct random audits of the resident records to ensure proper implementation of this rule. Responsible Party: Executive Director, Resident Care Director, Dietary Services Director	

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	HAL034099	A. BUILDING: _____ B. WING _____	07/06/2018

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D 358	Continued From page 40 revealed: -There was an entry for Ativan 0.05 mg, 1 tablet daily with meals scheduled at 8:00 am, 12:00 pm, and 8:00 pm. -Ativan was documented as administered at 8:00 am, 12:00 pm, and 8:00 pm from 06/01/18 to 06/30/18. -There was not an entry for Ativan 0.05 mg every 8 hours as needed for anxiety. Interview with a Medication Aide (MA)/Supervisor/Personal Care Aide (PCA) on 07/06/18 at 8:33 am revealed: -The Supervisor, Resident Care Coordinator (RCC) and the Resident Care Director (RCD) were responsible for reviewing hospital reports. -If hospital reports identified changes in a resident's medication, the Supervisor and RCC would contact the resident's physician for clarification and the pharmacy for changes to the eMAR if needed. -Resident #4 received Ativan 3 times a daily in the morning, at lunch, and in the evening. -She did not know if there had been any changes in Resident #4's order for Ativan. Interview with the Special Care Unit Coordinator (SCUC) on 07/06/18 at 9:19 am revealed: -Resident #4 had an order for Ativan 0.05 mg, 3 times day. -Resident #4 was seen by her Primary Care Physician on yesterday, 07/05/18, and the order for Ativan was changed to Ativan 0.05 mg every 6 hours as needed. -She did not know there was an order for Ativan 0.05 mg every 8 hours as needed on the hospital after visit summary. -The MA was responsible for reviewing hospital reports for new orders, documenting any changes in the medication or new orders in the 24 hour	D 358		

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D 358	Continued From page 41 shift notes, and discussing in the standup meeting the next morning. -The MA, Supervisor, or the RCD would contact the physician to clarify new orders and order medication. Review of a subsequent physician's order dated 07/05/18 provided by the SCUC revealed an order for Ativan 0.05 mg, one half tablet every 6 hours as needed for anxiety. Interview with the RCD on 07/06/18 at 1:55 pm revealed: -Resident #4 was on Ativan 0.05 mg 3 times daily, but her order for Ativan changed on yesterday, 07/05/18. -She did not know the about the Ativan order change on the hospital report. -The order for Ativan 0.05 mg every 8 hours as needed was not sent to the pharmacy to be put on the eMAR. -Resident #4 was seen by her PCP on 07/05/18 and her order for Ativan changed. Interview with the Executive Director on 07/06/18 at 2:52 pm revealed: -The RCC and the RCD were responsible for reviewing the hospital reports for changes in medication orders and communicating with the Supervisors. -If there were changes noted in the hospital reports, she expected the RCD or Supervisor to send any changes in orders to the pharmacy and to follow up with the resident's PCP. Interview with a pharmacy representative on 07/06/18 at 3:47 pm revealed: -The original order for Ativan for Resident #4 dated 12/18/17 was for 0.05 mg, 1 tablet 3 times daily with meals.	D 358		

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D 358	Continued From page 42 -The pharmacy had not received the order for the hospital summary dated 04/16/18 for Ativan 0.05 mg, 1 tablet every 8 hours as needed for anlety. -The only other order for Ativan for Resident #4 was dated 07/05/18 and was for 0.05 mg,one half tablet every 6 hours as needed for anxiety. -The pharmacy was responsible for adding medication to the eMAR, but was unable to do so without a physician's order. Attempted telephone interview with Resident #4's PCP on 7/3/18 at 11:27 am and on 7/6/18 at 10:41 am was unsuccessful.	D 358		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care	D 482	The facility has not and will not use physical restraint or any alternative equipment for physical restraint under any circumstances. The facility will ensure that any physical or mechanical equipment utilized to assist a resident for positioning or mobility purposes, efforts to help resident reduce decline in functioning and improve opportunity for the residence's independence are only utilized under the following circumstances: 1) the resident has a medical condition or symptoms that warrant the use of physical or mechanical equipment and would absolutely never be utilized as a restraint or for punitive purposes 2) used only in accordance with a physicians order 3) provides the least restrictive alternative possible which supports a residents need	8/6/18

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D 482	Continued From page 43 planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physical restraints were used only after an assessment and care planning process had been completed through a team process and used only with a written order from a physician for 1 of 1 sampled residents (#4) who resided in the Special Care Unit (SCU) and had an order for half rails. The findings are: Review of Resident #4's current FL2 dated 03/16/18 revealed:	D 482	4) used in to prevent potential decline in the residents conditioning and allow support in maintenance of the residents independence 5) used only after an assessment and care planning has been completed 6) the supportive equipment is used according to manufacturer's instruction and compliance with physician's orders 7) used in conjunction with alternatives which provide support in the resident's ability, independence, mobility or positioning and do not include restraint of any kind! The Resident Care Director, Executive Director or other qualified Carillon representative will verify any order for adaptive, physical or mechanical equipment to include such supports as bed rails upon receipt of the order. The Resident Care Director, Resident Care Coordinator, Executive Director will physically inspect all equipment upon implementation to ensure there is no component of restraint. The Executive Director, Resident Care Director or other qualified Carillon representative will conduct an audit of all mechanical or adaptive equipment ordered in support of the resident's need to ensure continued and on-going compliance. An evaluation of a resident's condition and need for mechanical or adaptive equipment will be	

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D 482	Continued From page 44 -Diagnoses included Alzheimer's disease and L5 Disk Disease. -She was contstantly disoriented. -The section for restraints was blank. -The recommended level of care was secured unit. -There was an order for one-fourth side rail for the bed. Observation of Resident #4's bedroom on 07/02/18 during the initial tour between 10:00 am and 11:30 am revealed: -Resident #4's bed was located parellell to the wall and window and had a trilateral half rail on the right side of the bed. -The one-fourth rail had an extension piece that had been extended to a half-length rail. -The rail was in the up position and there was a bed alarm hooked on the rail. Observation of Resident #4's room on 07/06/18 at 4:28 pm revealed: -The left side of Resident #4's bed was pushed flush against an air conditioner unit which extend approximately 1 foot from the wall. -Extending from the right side of the air conditioner along the wall and touching the perpendicular wall was a piece of unidentified equipment. -The head of Resident #4's bed touched the perpendicular wall. -There was only about one foot of open space on the left side towards the foot of the bed. -The half-length rail was in the up position on the right side. Review of a Resident #4's physician's order revealed: -There was no physician's order for half-length bed rails.	D 482	completed on a quarterly basis to ensure continuity of care and proper adjustments to the resident's service plan are implemented accordingly. This evaluation will include a review of resident's ability to safely utilize assistive device for purposes of mobilityl and repositioning. The Executive Director, Resident Care Director, Regional Operations Director, Regional Nurse or other qualified Carillon representative will conduct random audits of resident clinical records to ensure compliance with this requirement. Responsible Party: Executive Director, Resident Care Director	

Division of Health Service Regulation

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D 482	Continued From page 45 -There was no physical restraint consent form or documentation for alternative to restraint assessment. -There was an order for a bed alarm dated 06/28/18. Review of Resident #4's current assessment and resident care plan signed and dated 07/19/17 revealed: -Resident #4 was alert and oriented to self. - Resident #4 required limited assistance with transferring and supervision with ambulation/locomotion. - Resident #4 required extensive assistance with bathing, tolleting, dressing and grooming. - Resident #4 had no physical restraint documented on the care plan. Review of Resident #4's Licensed Health Professional Support (LHPS) review dated 02/27/18 revealed: -Resident #4 was noted to be oriented to person. -It was noted Resident #4 fell on 01/22/18 and was seen in the emergency room for a scalp contusion. -It was noted Resident #4 also had a fall on 01/25/18. -It was noted a one-fourth rail was ordered for Resident #4's bed. Review of Resident #4's LHPS review dated 07/04/18 revealed: -It was noted an order for bed alarm was in Resident #4's record. -There was no documentation for bed rails. Interview with the Special Care Unit Coordinator (SCUC) revealed: -Resident #4 "fell off her bed and fractured her	D 482		

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D 482	Continued From page 46	D 482		

neck, but she did not know how because she had a rail."
-The bed rail was in place because Resident #4's family was worried about her falling out of the bed.

Interview with Resident #4's family member on 07/06/18 at 10:53 pm revealed:
-The bed rail was purchased by Resident #4's family member.
-The facility staff wanted her to have it to keep her from falling out of the bed.

Interview with a physical therapist on 07/06/18 at 11:31 am revealed:
-The home health agency she worked for received a referral on 07/05/18 for a home health assessment for physical therapy and occupational therapy.
-She was at the facility today to complete an initial assessment for physical therapy.
-Resident #1 was scheduled for physical therapy visits 1 time a week for mobility.
-Resident #1 was able to get out of bed using her bed rail, but she had to be cued.
-"I would say that because there is a bed alarm in place, the bed rail is more for falls than repositioning."

Interview with a Personal Care Aide (PCA) on 07/06/18 at 11:41 am revealed Resident #4 had a bed alarm and bed rail to prevent falls.

Interview with the Resident Care Director (RCD) on 07/06/18 at 4:05 pm revealed:
-The order for the bedrail was for mobility.
-She did not know if Resident #4 was able to get out of a chair or bed alone.
-The bed rail was up all of the time.
-The bed rail was an extended one-fourth bed

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D 482	Continued From page 47 rail. -The bed rail was in the extended position on Resident #4's bed. -Resident #4 also had a bed alarm. -There had been no initial or subsequent assessments of Resident #4 for use of the bed rail. -The facility was considered to be a restraint free facility. Interview with a Medication Aide (MA)/PCA on 07/06/18 at 4:37 pm revealed: -Resident #4 was able to get out of bed by herself. -Resident #4 had a bed rail to prevent falls because "she had been known to fall out of bed." Interview with a PCA on 07/06/18 at 4:46 pm revealed: -She assisted Resident #4 with getting out of bed today. -The bed rail was for when she (Resident #4) was in bed so she would not roll over and fall. Interview with the Executive Director on 07/06/18 at 4:19 pm revealed: -She knew Resident #4 had a bed rail, but she did not know it was used in the extended one-fourth rail position as a half rail. -Resident had the bed rail because she had a tendency to fall out of bed. -She was not sure if an assessment had been completed in Resident #4 for the use of the bed rail. -The facility was considered a restraint free facility. Attempted telephone interview with Resident #4's PCP on 7/3/18 at 11:27 am and on 7/6/18 at 10:41 am was unsuccessful.	D 482		

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D 482	Continued From page 48 Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable	D 482		
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, interviews and record reviews, the facility failed to assure residents received care and services that are adequate, appropriate and in compliance with federal and state laws and rules and regulations related to Health care. The findings are: Based on observation, record reviews and interviews the facility failed to ensure physician notification for 1 of 5 sampled residents (Resident #1) with swollen and red feet, ankles and legs, and complaint of leg pain. [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912	Refer to D273 Plan of Correction	
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:	D914	Refer to D270 Plan of Correction,	

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D914	Continued From page 49 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that the residents were free of neglect as related to personal care and supervision and health care. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide supervision for 2 of 6 sampled residents (#1 and #4) who were disoriented and ambulatory resulting in repeated falls with injuries including a cervical vertebrae fracture (#4) and elopement from the Special Care Unit (SCU) (#1). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D914		