STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(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 February 26-28, 2019.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 2 of 5 sampled residents (Resident #1 and Resident #2) with blood pressure measurements outside of ordered parameters. The findings are: 1. Review of Resident #1's current FL-2 dated 01/21/19 revealed: -Diagnoses included hypertension, atrial fibrillation, and coronary artery disease. -There was a physician's order to check blood pressure (BP) once daily and notify the Primary Care Provider (PCP) if systolic blood pressure (SBP) was greater than 170 or less than 90 or if diastolic blood pressure (DBP) was greater than 110 or less than 60. -There was a medication order for Lopressor 50mg one tablet every morning (a medication used to treat high blood pressure)and Lopressor	D 273		

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D 273	Continued From page 1 50mg ½ tablet at bedtime. Review of Resident #1's signed physician's orders dated 08/14/18 and 02/04/19 revealed an order to check blood pressure BP once daily and notify the PCP if systolic BP was greater than 170 or less than 90 or if diastolic BP was greater than 110 or less than 60. Review of Resident #1's December 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check and record BP scheduled for 10:00am and notify the PCP if SBP was above 170 or less than 90 or the DBP was above 110 or less than 60. -Eleven of thirty-one BP readings were outside of the ordered parameters. -On 12/03/18, the BP reading was 95/52. -On 12/05/18, the BP reading was 105/57. -On 12/06/18, the BP reading was 103/56. -On 12/07/18, the BP reading was 109/53. -On 12/08/18, the BP reading was 95/47. -On 12/17/18, the BP reading was 104/50. -On 12/18/18, the BP reading was 101/57. -On 12/20/18, the BP reading was 88/48. -On 12/24/18, the BP reading was 110/58. -On 12/26/18, the BP reading was 108/51. -On 12/27/18, the BP reading was 101/49. Review of Resident #1's January 2019 eMAR revealed: -There was an entry to check and record BP scheduled for 10:00am and notify the PCP if SBP was above 170 or less than 90 or the DBP was above 110 or less than 60. -Two of thirty-one BP readings were outside of the ordered parameters. -On 01/03/19, the BP reading was 145/57. -On 01/15/19, the BP reading was 125/58.	D 273		

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D 273	Continued From page 2 Review of Resident #1's February 2019 eMAR from 02/01/19 through 02/26/19 revealed: -There was an entry to check and record BP scheduled for 10:00am and notify the PCP if SBP was above 170 or less than 90 or the DBP was above 110 or less than 60. -BP readings ranged from 98/62 to 170/97. Review of Resident #1's Progress Notes revealed no documentation the PCP had been notified of any BP outside of ordered parameters in December 2018 or January 2019. Interview with a morning shift medication aide (MA) on 02/27/19 at 10:15am revealed: -She knew Resident #1 had an order to check his BP daily and notify the PCP if the BP was outside of the ordered parameters. -She could not remember a time when she had checked Resident #1's BP and the reading was outside of ordered parameters. -It was the MA's responsibility to contact the PCP and document the contact in the resident's Progress Notes. Interview with a second morning shift MA on 02/27/19 at 11:32am revealed: -She knew Resident #1 had an order to check his BP daily and notify the PCP if the BP was outside of the ordered parameters. -She documented Resident #1's BP readings outside of ordered parameters eight times in December 2018 and two times in January 2019. -It was the MA's responsibility to contact the PCP to notify him when BP readings were outside the ordered parameters. -If she had notified the PCP, she would have documented the contact in Resident #1's Progress Notes.	D 273		

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-Because there was no documentation of contact with Resident #1's PCP, she probably had not contacted the PCP.
-"I probably got so busy I forgot to call (the PCP)."

Telephone interview with the Registered Nurse (RN) at Resident #1's PCP office on 02/28/19 at 11:17am revealed:
-The PCP had ordered BP checks and parameters for Resident #1 due to his history of hypertension.
-The facility had not notified the PCP regarding any BP readings outside ordered parameters in December 2018 or January 2019.
-The PCP wanted to be notified of BP readings outside of ordered parameters in case he needed to adjust Resident #1's BP medications or have the facility staff measure his BP more often.

Refer to interview with the Resident Care Director (RCD) on 02/28/19 at 12:05pm.

Refer to interview with the Administrator on 02/28/19 at 10:54am.

2. Review of Resident #2's current FL2 dated 04/17/18 revealed diagnoses included hypertension and acute kidney failure.

Review of Resident #2's signed physician's orders dated 08/15/18 and 02/07/19 revealed an order to check blood pressure (BP) daily and notify the primary care provider (PCP) if the systolic BP was above 170 or less than 100 or the diastolic BP was above 100 or less than 55.

Review of Resident #2's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check BP daily and notify

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the PCP if the systolic BP was above 170 or less than 100 or the diastolic BP was above 100 or less than 55.
-The scheduled time on the MAR to obtain the BP reading was 9:00 am.
-There were five readings that were outside of the ordered parameters from 12/01/18-12/31/18.
-The documented BP readings ranged from 150/71-86/41.
-On 12/03/18, the BP reading was 95/52.
-On 12/06/18, the BP reading was 94/43.
-On 12/08/18, the BP reading was 86/41.
-On 12/17/18, the BP reading was 94/46.
-On 12/30/18, the BP reading was 120/49.
-There was no documentation the physician was notified of the BPs that were outside the ordered parameters.

Review of the "Resident Progress Notes" for Resident #2 revealed there was no documentation the PCP was notified of the BP readings obtained for December 2018.

Review of Resident #2's January 2019 eMAR revealed:
-There was an entry to check BP daily and notify the PCP if the systolic BP was above 170 or less than 100 or the diastolic BP was above 100 or less than 55.
-The scheduled time on the MAR to obtain the BP reading was 9:00 am.
-There were seven readings that were outside of the ordered parameters from 01/01/19-01/31/19.
-The documented BP readings ranged from 150/70-96/48.
-On 01/01/19, the BP reading was 100/44.
-On 01/08/19, the BP reading was 103/52.
-On 01/09/19, the BP reading was 98/56.
-On 01/15/19, the BP reading was 125/48.
-On 01/16/19, the BP reading was 120/52.

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-On 01/21/19, the BP reading was 96/48.
-On 01/31/19, the BP reading was 101/47.
-There was no documentation the physician was notified of the BP that were outside the ordered parameters.

Review of Resident #2's record revealed there was no documentation the physician was notified of the BP readings obtained for January 2019.

Review of Resident #2's February 2019 eMAR revealed:
-There was an entry to check BP daily and notify the PCP if the systolic BP was above 170 or less than 100 or the diastolic BP was above 100 or less than 55.
-The scheduled time on the MAR to obtain the BP reading was 9:00 am.
-There were three readings that were outside of the ordered parameters from 02/01/19-02/26/19.
-The documented BP readings ranged from 158/61-96/43.
-On 02/14/19, the BP reading was 96/43.
-On 02/15/19, the BP reading was 149/51.
-On 02/22/19, the BP reading was 127/54.
-There was no documentation the physician was notified of the BP readings.

Review of Resident #2's record revealed there was no documentation the physician was notified of the BP readings obtained for February 2019.

Interview with a first shift medication aide (MA) on 02/27/19 at 2:06pm revealed:
-She knew Resident #2 had an order to obtain BPs daily with ordered parameters.
-The MAs were responsible for obtaining the BP as ordered and notifying the PCP for BPs outside of parameters.
-When the PCP was notified, the contact should

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be documented in the resident progress notes.
-She called and notified the physician when Resident #2's BPs were outside of the parameters on 12/30/18, 02/14/19, and 02/22/19.
-She could not remember who she spoke to at the physician's office, however they instructed her to recheck the BP, and no other follow-up was required.
-The contact to Resident #2's physician should have been documented in the resident progress notes "it was an oversight".
-"I did not record that I notified the physician, I may have gotten busy".
-She had not documented her contact with Resident #2's physician.
-The MA was responsible for obtaining BPs, notifying the PCP, and recording the BP.

Interview with another first shift MA on 02/27/19 at 02/27/19 at 2:57pm revealed:
-She knew Resident #2 had an order to notify the physician if BPs were outside of parameters.
-She had called the physician, however could not remember when she called and who she spoke to.
-She was instructed by someone at the physician's office, to get Resident #2 to drink more water.
-She rechecked the BP for Resident #2 "later" when the BP was outside of parameters, but did not document in the record or progress notes.
-The physician told her to increase Resident #2's water intake.
-When the physician was notified, the contact should be documented in the resident progress notes.
-She obtained and recorded Resident #2's BPs on 12/03/18, 12/06/18, 12/08/18, 12/17/18, 01/08/19, 01/09/19, 01/15/19, 01/16/19, 01/21/19, and 01/31/19.

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D 273	Continued From page 7 -She could not remember which dates she contacted the physician about Resident #2s BPs. -"I probably did not do it, I may not have had time". -"I know I called at least once, sometimes I can call and sometimes I don't, I don't remember". -She told the Resident Care Director (RCD) about BPs outside of parameters at least "once or twice", but could not remember the date. Interview with an additional first shift MA on 02/28/19 at 11:03am revealed: -She obtained and recorded the BPs for Resident #2 on 01/01/19 and 02/15/19. -She had not noticed the order for Resident #2's BP parameters. -She had never contacted the PCP regarding Resident #2's BPs because she did not notice the ordered parameters. Telephone interview with Resident #2's primary care physician (PCP) on 02/27/19 at 3:19pm revealed: -He ordered staff to check BP daily with parameters due to history of hypertension and heart failure. -He expected staff to check Resident #2's BP as ordered and notify him of BP outside of parameters. -He had not been notified of any BP readings outside the ordered parameters in December 2018, January 2019, or February 2019. -He would have instructed staff to monitor resident for symptoms of hypotension. -Resident #2 would be at risk for "passing out and feeling faint" if her BP was too low. Refer to interview with the Resident Care Director (RCD) on 02/28/19 at 12:05pm.	D 273		

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D 273	Continued From page 8 Refer to interview with the Administrator on 02/28/19 at 10:54am. _____ Interview with the Resident Care Director (RCD) 02/28/19 at 12:05pm revealed: -MAs were responsible for obtaining BPs and notifying the PCP if readings were outside of the ordered parameters. -MAs were responsible for documenting that the physician was notified in the resident progress notes. -He did not know the physician was not notified of the BP readings outside the parameters December 2018, January 2019, and February 2019. -He was responsible for overseeing the MAs and reviewing the MARs for BP readings and follow-up with the physician. -He had not had time to review the MARs to ensure the MAs were following the physician orders. Interview with the Administrator on 02/28/19 at 10:54am revealed: -If there were ordered BP parameters, she expected the MAs to notify the PCP regarding BPs outside of parameters. -The MAs should be documenting when they call the physician in the resident progress notes. -She did not know there were any residents in the facility with orders to notify the physician if BP's were outside of parameters.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record:	D 276		

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D 276	Continued From page 9 (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, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 5 sampled residents regarding the application and removal of thromboembolic deterrent hose (Resident #4). The findings are: Review of Resident #4's current FL-2 dated 01/10/19 revealed: -Diagnoses included Alzheimer's disease and chronic kidney disease. -There was an order for thromboembolic deterrent (TED) hose provide after washing legs and applying hydrocortisone and Aquaphor lotion. Review of Resident #4's signed physician's orders dated 08/15/18 revealed an order to provide TED hose daily after washing legs and applying hydrocortisone and Aquaphor lotion. Review of Resident #4's current Care Plan dated 01/06/19 revealed he was totally dependent on staff for dressing and washing his lower extremities.	D 276		

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D 276	Continued From page 10 Observation of Resident #4 on 02/27/19 at 11:32am revealed he did not have TED hose on his legs. Observation of Resident #4 on 02/28/19 at 12:47pm revealed he did not have TED hose on his legs. Review of Resident #4's February 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply TED hose after washing legs and applying hydrocortisone and Aquaphor lotion scheduled on at 6:00am and off at 8:00pm. -There was documentation Resident #4's TED hose had been applied every day at 6:00am from 02/01/19 through 02/28/19 with the exception of 02/06/19. -There was documentation on 02/06/19, TED hose were not applied due to "missed dose." -There was documentation Resident #4's TED hose were removed every day at 8:00pm from 02/01/19 through 02/27/19. Interview with a morning shift medication aide (MA) on 02/27/19 at 11:32am revealed: -The night shift MA was responsible for applying Resident #4's TED hose and the evening shift MA was responsible for removing them. -She did not routinely check to see if a resident was wearing TED hose because morning shift MAs were not responsible for applying or removing them. -She had not realized Resident #4 was not wearing his TED hose until now (02/27/19 at 11:32am). -Residents' TED hose would usually be kept in a drawer in their room or hanging up in the laundry	D 276		

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room.
-She checked the medication cart, Resident #4's room and the laundry room and could not locate Resident #4's TED hose.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

Telephone interview with Resident #4's responsible party (RP) on 02/27/19 at 2:04pm revealed:
-She did not get to visit the facility often.
-The last time she visited Resident #4 was in early January 2019.
-She did not know he had an order for TED hose and had never seen him wearing them.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 02/27/19 at 3:48pm revealed:
-Resident #4 had an order for TED hose because he had a habit of "ripping his legs apart with his fingernails creating constant wounds."
-He had ordered TED hose to serve as a barrier to Resident #4's legs to help protect them from Resident #4 scratching and to prevent the creation of new wounds.
-He last visited Resident #4 on 01/10/19 and he was wearing TED hose on one of his legs at that time.
-Resident #4 was receiving home health skilled nursing services for wound care.
-He expected facility staff to take direction from the home health nurse (HHN) performing wound care for Resident #4. If she recommended staff not apply TED hose to the leg with the wound and only apply it to the leg without a wound, he was okay with them doing as instructed.
-He did not know why Resident #4 was not

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D 276	Continued From page 12 wearing TED hose on either leg on 02/27/19 and 02/28/19. Telephone interview with the HHN on 02/28/19 at 11:54am revealed: -She was providing wound care for Resident #4. -Resident #4 had a physician's order for TED hose because they helped to create a barrier to protect his skin from scratches. -She had last visited Resident #4 on 02/27/19 around 6:00pm. -She observed Resident #4 not wearing TED hose on 02/27/19 at 6:00pm and "she was concerned." -Resident #4 had not been wearing TED hose during any of her visits over the past two weeks. -She spoke with the Resident Care Director (RCD) on 02/27/19 and he told her he would need to get a physician's order and get an entry added to the eMAR before facility staff could apply TED hose to Resident #4. -She had instructed staff to apply a TED hose to Resident #4's leg or both legs if they did not have open wounds being treated. -She did not want staff to apply TED hose to the leg she was treating for a wound but expected them to apply TED hose to the opposite leg for protection and to increase blood circulation to prevent future wounds. Interview with a second MA on 02/28/19 at 12:47pm revealed: -Resident #4 wore a TED hose on one of his legs, the leg that did not have a wound. -She worked last night (02/27/19) and had removed Resident #4's TED hose around 8:00pm. -She did not know why Resident #4 was observed without his TED hose on 02/27/19 at 11:32am and again by the HHN on 02/27/19 at 6:00pm.	D 276		

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-She did not know why Resident #4 was not currently wearing TED hose even though it was documented on the eMAR as being applied at 6:00am.
-She was able to locate one TED hose in Resident #4's room and applied it to his right leg (the leg without the wound).

Telephone interview with a night shift MA on 02/28/19 at 1:10pm revealed:
-She applied one TED hose to Resident #4's leg on 02/27/19 around 7:00am.
-She applied the TED hose to Resident #4's leg with the wound because she thought that was the physician's order.
-She did not know why Resident #4 was observed without his TED hose on 02/27/19 at 11:32am and again by the HHN on 02/27/19 at 6:00pm.
-Resident #4 was able to remove his TED hose.

Attempted telephone interview with the night shift MA who documented the application of Resident #4's TED hose on 02/28/19 at was unsuccessful at 1:04pm.

Interview with the Special Care Unit (SCU) Coordinator on 02/28/19 at 1:21pm revealed:
-It was the night shift MA's responsibility to apply TED hose for residents.
-It was the evening shift MA's responsibility to remove the TED hose.
-She never checked to see if Resident #4 was wearing TED hose.
-She had never observed Resident #4 removing his TED hose.

Interview with the RCD on 02/28/19 at 1:44pm revealed:
-He provided oversight to the MAs.
-Resident #4 had been receiving wound care

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D 276	Continued From page 14 from the HHN. -He thought MAs were not applying TED hose to Resident #4 because he was not supposed to wear them since he was receiving wound care. -He did not know Resident #4 had current physician's orders for TED hose. -A MA would document the medication and treatment orders on renewal FL-2s using the current eMAR. -He would then complete the remaining sections of the renewal FL-2s and send them to the PCP for his signature. -He did not routinely review the orders on the FL-2s prior to sending them to the PCP or after receiving them back from the PCP. -He did not audit the eMARs because he did not have time to do so and had not seen the entry for Resident #4's TED hose on the eMAR. Interview with the Administrator on 02/28/19 at 2:01pm revealed: -She did not know why Resident #4 had been observed multiple times on 02/27/19 and 02/28/19 without TED hose on. -She expected the MAs to follow the PCP's orders. -It was the responsibility of the night shift MA to apply the TED hose and it was the responsibility of the evening shift MA to remove them. -It was the responsibility of the RCD to complete renewal FL-2s and review them for accuracy. -It was the RCD's responsibility to contact the PCP if he had questions regarding the order for TED hose.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 310		

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D 310	Continued From page 15 (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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 2 of 3 sampled residents (Resident #4 and #3) with diet orders for blender prepared meals and nectar thickened liquids (#4) and ground meats (#3). The findings are: 1. Review of Resident #4's current FL-2 dated 01/10/19 revealed: -Diagnoses included Alzheimer's Disease. -There was an order for a blender prepared diet. Review of the therapeutic diet list dated 02/21/19 revealed Resident #4 was to be served a blender prepared diet with nectar thickened liquids. a. Telephone interview with Resident #4's Primary Care Physician (PCP) on 02/27/19 at 3:48pm revealed: -Resident #4's current diet order was blender prepared meals with nectar thickened liquids. -Resident #4 had an episode of choking since his	D 310		

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admission to the facility on 03/27/15, but he could not recall the exact date.
-He had referred Resident #4 for a speech evaluation at that time and they had recommended his current diet order.
-Resident #4 was at risk for aspiration if he consumed thin liquids instead of nectar thickened liquids.

Review of the therapeutic diet menu for lunch on 02/26/19 revealed residents on a blender prepared diet should be served blended chicken, blended corn, green beans, bread mix and applesauce.

Observation of the lunch meal service in the Special Care Unit (SCU) dining room on 02/26/19 from 12:00pm to 1:00pm revealed:
-The Administrator served Resident #4 unsweetened tea which was not nectar thickened.
-Resident #4 consumed none of the unsweetened tea not thickened.
-After prompting, Resident #4 was served nectar thick tea, nectar thick milk and nectar thick water.
-Resident #4 was served blended chicken, blended green peas, mashed potatoes and pudding.

Interview with the Administrator on 02/28/19 at 10:31am revealed:
-She typically did not assist with serving during meal service.
-There was a copy of the therapeutic diet list posted on the inside of the warmer used to transport the plates to the SCU from the kitchen.
-The warmer had not arrived from the kitchen when she began serving beverages so she did not know where to reference the therapeutic diet list.
-She asked another staff member, who routinely

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assisted with meal service, which resident was on nectar thickened liquids and thought the staff person had pointed to Resident #4's neighbor.
-She was not familiar with all the residents' names and served Resident #4 thin liquids in error.

Telephone interview with Resident #4's Speech Therapist on 02/28/19 at 12:25pm revealed:
-Resident #4 was last evaluated by her in September 2018.
-At that time, Resident #4 had constant coughing and redness in the face when trialed on thin liquids so she recommended he be served only nectar thickened liquids.
-Resident #4 was not a good candidate to have a swallow study performed due to his cognitive impairment and would need to continue on nectar thickened liquids.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

Telephone interview with Resident #4's responsible party (RP) on 02/27/19 at 2:04pm revealed:
-She did not get to visit the facility often.
-The last time she visited Resident #4 was in early January 2018.
-She knew his diet order was for blender prepared meals and nectar thickened liquids.
-He had a choking episode in the past since living at the facility, but she could not remember when.

Refer to interview with the Dining Services Coordinator on 02/27/19 at 2:30pm.

Refer to interview with the SCU Coordinator on 02/27/19 at 3:00pm.

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D 310	Continued From page 18 Refer to interview with the Administrator on 02/28/19 at 10:31am. b. Review of the therapeutic diet menu for breakfast on 02/27/19 revealed residents on a blended diet should be served hot or cold cereal, breakfast bread, blended pork, and egg. Observation of the breakfast meal service in the Special Care Unit (SCU) dining room on 02/27/19 from 8:00am to 8:45am revealed: -Resident #4 was served oatmeal, grits, nectar thick milk, nectar thick water and nectar thick cranberry juice. -Resident #4 was not served breakfast bread, blended pork or an egg. -Resident #4 consumed 100% of his meal. Interview with a Personal Care Aide (PCA) serving breakfast on 02/27/19 at 8:15am revealed: -The kitchen staff plated all meals and sent them to the SCU in a warmer box. -Resident #4's breakfast typically consisted of oatmeal and yogurt. -She was not sure why the kitchen staff had sent oatmeal and grits. Interview with the Dining Services Coordinator on 02/27/19 at 8:40am revealed: -He did not prepare breakfast on 02/27/19; another cook prepared it. -Typically when he was the cook assigned to prepare breakfast, he would blend sausage or bacon into oatmeal for Resident #4. -He did not typically serve an egg to Resident #4 because he thought he preferred yogurt instead. Interview with the breakfast cook on 02/27/19 at	D 310		

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D 310	Continued From page 19 8:45am revealed: -She prepared and plated oatmeal and grits for Resident #4's breakfast on 02/27/19. -She was the breakfast cook three days per week and she always sent oatmeal, mashed banana and yogurt to be served to Resident #4. -She did not send mashed banana and yogurt on 02/27/19 because they had a truck delivery and boxes were blocking her access to the bananas and yogurt. -She never prepared blended pork, eggs or breakfast bread for Resident #4's breakfast. -She had been trained two years ago by a former cook to serve only oatmeal, mashed banana and yogurt for breakfast for residents on a blended diet. -She had never seen the facility's therapeutic diet menus and only used the Week at a Glance regular diet menu to prepare meals for all residents. Telephone interview with Resident #4's Primary Care Physician (PCP) on 02/27/19 at 3:48pm revealed: -Resident #4's current diet order was blender prepared meals with nectar thickened liquids. -Resident #4 had an episode of choking since his admission to the facility on 03/27/15, but he could not recall the exact date. -He had referred Resident #4 for a speech evaluation at that time and they had recommended thw current diet order. -He expected Resident #4 to be served all items listed on the therapeutic diet menu including breakfast meat and eggs. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	D 310		

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Telephone interview with Resident #4's responsible party (RP) on 02/27/19 at 2:04pm revealed:
-She did not get to visit the facility often.
-The last time she visited Resident #4 was in early January 2018.
-She knew his diet order was for blender prepared meals and nectar thickened liquids.
-He had a choking episode in the past since living at the facility, but she could not remember when.

Refer to interview with the Dining Services Coordinator on 02/27/19 at 2:30pm.

Refer to interview with the SCU Coordinator on 02/27/19 at 3:00pm.

Refer to interview with the Administrator on 02/28/19 at 10:31am.

2. Review of Resident #3's current FL2 dated 01/18/19 revealed:
-Diagnoses included dementia and dysphagia.
-There was an order for a ground meats diet.

Review of the therapeutic diet list dated 02/21/19 revealed Resident #3 was to be served a ground meats diet.

Review of the therapeutic diet menu for lunch on 02/26/19 revealed residents on a ground meats diet were to be served ground chicken, corn on the cob, green beans, a dinner roll, and fruit salad.

Observation of the lunch meal service on 02/26/19 from 12:00pm to 1:00pm revealed:
-Resident #3 was served meatloaf, mashed potatoes, corn, tea, water, and milk.
-Resident #3's meatloaf was intact and was not

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ground.
-After prompting, a personal care aide (PCA) removed Resident #3's plate before she was able to eat the meatloaf.
-Resident #3 received a new plate of food that included ground meatloaf with gravy.
-Resident #3 ate her lunch meal without difficulty.

Interview with a PCA serving lunch on 02/26/19 at 1:06pm revealed:
-The kitchen staff plated all meals and sent them to the SCU in a warmer box.
-She referred to the diet list that was posted in the food warmer.
-She knew Resident #3 was to be served a ground meats diet.
-The meatloaf was never ground when served but it was always soft.
-She would cut up the meat for Resident #3 because she did not always have time to get another plate from the kitchen.
-She had not asked the dietary manager about grinding Resident #3's meat.

Review of the therapeutic diet menu for breakfast on 02/27/19 revealed residents on a ground meats diet were to be served hot or cold cereal, breakfast bread, ground bacon or sausage, egg, milk, and juice of choice.

Observation of the breakfast meal on 02/27/19 from 8:00am-8:45am revealed:
-Resident #3 was served chopped sausage, scrambled eggs, oatmeal, and a biscuit.
-Resident #3 consumed her breakfast meal without difficulty.

Interview with the breakfast cook on 02/27/19 at 8:45am revealed:
-She prepared and plated sausage for Resident

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D 310	Continued From page 22 #3 on 02/27/19. -She knew Resident #3 was on a grind all meats diet. -She chopped Resident #3's sausage using a spatula. -She was the breakfast cook three days per week and she never ground sausage because "it turned to mush" if she did. Interview with the primary care physician (PCP) for Resident #3 on 02/28/19 at 9:05am revealed: -The resident was ordered ground meats diet due to her diagnosis of dysphagia. -Resident #3 had a swallowing test completed a "couple of years ago" and failed. -Resident #3 would be at risk of choking if meats were not ground. -She would not recommend Resident #3 to receive regular meat. Refer to interview with the Dining Services Coordinator on 02/27/19 at 2:30pm. Refer to interview with the SCU Coordinator on 02/27/19 at 3:00pm. Refer to interview with the Administrator on 02/28/19 at 10:31am. Based on observations, interview, and record review it was determined Resident #3 was not interviewable. Interview with the Dining Services Coordinator on 02/27/19 at 2:30pm revealed: -He was both a cook and the Dining Services Coordinator. -Meals were plated in the kitchen and carted to the SCU in a warmer. -Therapeutic diet plates were covered in plastic	D 310		

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wrap to alert the staff there was a difference in those and the regular diet plates.
-Servers in the SCU referenced the therapeutic diet list taped to the inside of the warmer to know which diet to serve to which resident.
-The SCU Coordinator also kept a copy of the therapeutic diet list somewhere in the SCU, but he was not sure where she kept it.
-Each day, he posted the Week at a Glance Menu for regular diets in the kitchen for the cooks to reference.
-He kept the therapeutic menu in a binder notebook in the kitchen.
-All dietary staff had access to the therapeutic menus in the binder and should know to reference them when preparing therapeutic diets.
-He was responsible for training and oversight to the dietary staff.
-He did not observe the breakfast cook, because if she were there to prepare breakfast, he came into work later on those days.
-When he was cooking, he always used the grinder to grind meats.

Interview with the SCU Coordinator on 02/27/19 at 3:00pm revealed:
-She maintained a copy of the therapeutic diet list in a binder at the SCU nurse's station.
-If a new resident came to the facility or if there was a change made to a resident's diet order, the information was communicated to the SCU staff during daily shift change meetings.
-If a staff person was unsure of what diet to serve a resident, they should reference the therapeutic diet list in the binder or inside the food warmer.
-If the kitchen staff sent something to the SCU that was not appropriate for a resident's diet, the SCU serving staff should alert her and she could go to the kitchen to get whatever was needed.

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D 310	Continued From page 24 Interview with the Administrator on 02/28/19 at 10:31am revealed she expected staff to use the resources they had been provided, including the therapeutic diet list and the therapeutic menus, to serve all diets as ordered by the physician. The facility failed to serve Resident #4, who failed a swallowing evaluation, a nectar thickened diet as ordered placing him at risk for aspiration and failed to serve Resident #3, with a diagnosis of dysphagia, a ground meats diet as ordered placing her at risk for choking. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/28/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 14, 2019.	D 310		
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	D912		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(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
D912	Continued From page 25 reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to serving therapeutic diets as ordered. The findings are: Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 2 of 3 sampled residents (Resident #4 and #3) with diet orders for blender prepared meals and nectar thickened liquids (#4) and ground meats (#3). [Refer to Tag 310 10A NCAC 13F .0904 (e) (4) Nutrition and Food Service (Type B Violation)].	D912		