STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	05/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation from 05/21/19 to 05/23/19. The complaint investigation was initiated by the Forsyth County Department of Social Services on 05/16/19.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to provide personal care assistance based on the assessed care plan for 1 of 3 sampled residents (Resident #1) who required extensive hands-on assistance transfers and toileting which resulted in a fall. The findings are: Review of Resident #1's current FL2 dated 04/10/19 revealed: -Diagnoses included reduced mobility, neuralgic	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	05/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 1 amyotrophy, cerebral infarction cervicalgia, hyperlipidemia, myalgia, hypertension, major depressive disorder, chest pain, pain in left leg, shortness of breath, trochanteric bursitis, radiculopathy, and squamous cell carcinoma. -The resident was documented to be non-ambulatory. -Personal care assistance was documented as total care with bathing and dressing. -The resident was documented to be incontinent with bladder. Review of Resident #1's Care Plan signed by the physician on 12/31/18 revealed: -The resident needed assistance with Activities of Daily Living (ADLs) as follows: -Extensive assistance was required with toileting, bathing, dressing, grooming and transferring. -Total dependence was required for ambulation. Review of the Resident #1's "personal care sheets" for March 2019 revealed: -Staff were to provide extensive transfer assistance with bed/chair/toileting transfers. -Staff were to provide "hands on" assist on and off the toilet. -I was documented staff was to provide this service to the resident daily on the first, second and third shifts from March 1, 2019 through March 31, 2019. Review of the Resident #1's personal care sheets for April 2019 revealed: -Staff were to provide extensive transfer assistance with bed/chair/toileting transfers. -Staff were to provide "hands on" on and off the toilet. -It was documented staff was to provide this service to the resident daily on the first, second and third shifts from April 1, 2019 through April	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	05/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 2 30, 2019. Review of the Resident #1's personal care sheets for May 2019 revealed: -Staff were to provide extensive transfer assistance with bed/chair/toileting transfers. -Staff were to provide "hands on" on and off the toilet. -It was documented staff was to provide this service to the resident daily on the first, second and third shifts from May 1, 2019 through May 17, 2019. Review of a home health physical therapy agency report from September 2018 revealed: -The resident was receiving services for physical therapy and leg wraps. -The therapist assessed Resident #1 for toileting transfers as being totally dependent upon facility staff. -The therapist assessed the resident as being unable to transfer self. -Physical therapy services were discontinued in February 2019 with no recommendations for facility staff regarding transfers. Review of a second home health physical therapy agency report from March 2019 revealed: -The resident was receiving therapy services for leg wraps. -The therapist documented the resident was able to transfer to and from the toilet when reminded, supervised or assisted by another person. -Resident #1 had impaired balance. -Resident #1 was at risk for falling. -The resident had decreased strength in her lower extremities. -The resident was currently receiving these services.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	05/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 3	D 269		

Review of emergency medical responders report dated 05/17/19 revealed:
-A phone call was received at 7:49am regarding a resident fall.
-Upon arrival Resident #1 was observed on the bathroom floor.
-The resident expressed pain after the fall with injury, multiple trauma and shortness of breath.
-The resident was transported to the hospital.

Review of the Licensed Health Professional Services (LHPS) evaluation dated 05/02/19 revealed the RN noted in her assessment that Resident #1 required two staff to assist with transferring.

Telephone interview with the LHPS Nurse on 05/22/19 at 5:36pm revealed:
-She completed the LHPS review on Resident #1.
-She reviewed Resident #1's record, orders, home health notes, 24-hour staff log and assessed the resident.
-Based on interviews with staff it was determined Resident #1 was a two person assist.

Interview with Resident #1's family member on 05/21/19 at 3:49pm revealed:
-Resident #1 was hospitalized on 05/17/19 due to injuries which resulted from a fall that happened at the facility.
-The resident told her she was in the bathroom with one staff person inside the bathroom.
-A second staff was outside the bathroom door and did not come inside the bathroom.
-Resident #1 said when she got off the toilet she lost her balance.
-The staff in the bathroom with her did not try to assist her when she started to fall but let her fall to the floor.
-The second staff still did not come into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	05/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 4	D 269		

bathroom to assist the resident.
-She was not at the facility, but Resident #1 told her about the incident.

Resident #1 was not available for interview.

Interview with the personal care aide (PCA) on 05/22/19 at 9:15am revealed:
-On the morning of 05/17/19 at around 7:30am she assisted Resident #1 to the bathroom in her wheelchair following the process that she usually followed.
-Resident #1 was standing, and she thought the resident was holding onto the grab bar as she usually did, but she could not see the resident's hand when she was standing.
-Resident #1 started to pivot herself and lost her balance.
-She could not see if the resident was holding onto the grab bar.
-She noticed the resident falling and it was happening fast, all she could think to do was to guide the resident's head, so her head did not hit the wall.
-When Resident #1 landed on the floor she was on her left side.
-Resident #1 yelled "help, help, help" and complained of pain in her back and leg.
-After the fall she yelled for the other PCA to go get the medication aide (MA) on duty.
-If Resident #1 did not specifically ask for her help she did not provide hands on assistance with transferring.
-Sometimes Resident #1 asked for hands on assistance when toileting.
-The week prior to the fall Resident #1 did not ask for hands on assistance, and she did not volunteer hands on assistance.
-When she went to assist Resident #1 another PCA was there standing in Resident #1's room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	05/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 5	D 269		

outside the bathroom door.
-The PCA that was standing outside the bathroom door was there only to observe, but did not come into the bathroom.
-The other PCA did not come into the bathroom.

Second interview with the PCA on 05/23/19 at 3:35pm revealed:
-She knew the services to provide Resident #1 because she reviewed the facility's personal service sheets on the computer.
-She could not recall if Resident #1 needed extensive assistance or supervision.
-If personal service sheets were signed, it was the MAs that signed them.
-When she assisted Resident #1 she was always the only staff that personally assisted the resident.
-She did not provide hands on assistance unless the resident stated, "help me."
-Resident #1 was non-ambulatory but was able to transfer herself from a sitting position without hands on assistance.
-She usually worked first shift, and when she assisted Resident #1 in the morning the resident lifted herself up in the bed using the automatic lift.
-Resident #1 was not able to move her legs, so staff moved the resident's legs from the bed to the floor.
-With the resident sitting on the side of the bed, she moved the wheelchair in front of the resident.
-Resident #3 transferred herself by slowly standing and then she very slowly pivoted herself holding onto the wheelchair and the bed.
-Resident #3 asked staff was her backside straight in front of the wheelchair before sitting in down in the wheelchair.
-She rolled the resident in the wheelchair to the bathroom.
-When she got the resident into the bathroom,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	05/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 6	D 269		

she pushed the resident in the wheelchair directly in front of the toilet.
-Resident #1 transferred herself from the wheelchair to the toilet by using both of her hands to hold onto the grab bar that was on the wall near the toilet.
-Resident #1 pulled herself out of the wheelchair holding onto the grab bar.
-After the resident was standing, she moved the wheelchair away from the resident and put the wheelchair by the bathroom door.
-Resident #3 very slowly pivoted herself and turned her body holding onto the grab bar with one hand.
-The resident asked staff if she was positioned properly before sitting down on the toilet.
-When getting off the toilet Resident #1 usually told staff she was ready.
-Resident #1 slowly pulled herself up from a sitting position using the grab bar.
-She observed the resident sometimes struggled to get off the toilet, but she did not help the resident unless the resident stated, "help me."
-She pulled up the resident's brief up and fixed the resident's clothes.
-With the resident standing she pulled the wheelchair in front of the resident.
-Resident #1 slowly pivoted her body because she was facing the wheelchair.
-The resident continued to hold the grab bar on the wall with one hand and held onto the wheelchair with the other hand.
-When the resident's back was to the wheelchair she asked was she positioned properly, and she verbally guided the resident and told her when it was okay to sit down in the wheelchair.

Interview with the second PCA on 05/22/19 at 9:25am revealed:
-On 05/17/19 around 7:30am Resident #1 had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	05/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 7 fall in the bathroom. -She was in Resident #1's room but was standing outside the bathroom door and did not enter the room. -She did not visually see what was happening in the bathroom. -She heard the resident say she was ready and shortly afterwards she heard the resident yelling for help. -The PCA in the bathroom with the Resident #1 told her to go and get the MA on duty. -She recalled reviewing personal service sheets but did not recall exactly the required service for Resident #1's transfers. Interview with a medication aide (MA) on 05/23/19 at 9:34am revealed: -She was the MA on duty the morning that Resident #1 went to the hospital. -Two PCAs were in the room with Resident #1 on 05/17/19 in the morning. -One PCA was there assisting the resident in the bathroom. -The second PCA was standing outside the bathroom door. -One PCA came and told her the resident had had fallen to the floor. -She went down to the room and the resident was on the floor. -The resident was yelling "help, help, help" she did not assess the resident, but called 911. -Resident #1 had personal service sheets on the computer. -Before working with a resident staff were to review the personal service sheets to know what services the resident needed. -She thought Resident #1's personal service sheets required supervision standby assistance with transfers, but was not sure because she had not reviewed the sheets.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	05/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 8 -When she assisted Resident #1 supervision assistance was provided. Interview with two MAs 05/22/19 at 9:48am and 05/22/19 at 5:22pm revealed: -Resident #1 had lymphedema in her legs, which caused major mobility issues. -Resident #1 was more hands on and sometimes it took two staff to help the resident with moving her legs. -The resident was able to stand and transfer when getting into bed and on and off the toilet with staff holding one arm. -The resident did not like two staff people in her room, and if two staff came to the room the resident would yell for one of the two staff to get out of her room. -The resident's refusal for two staff to assist was not specifically with transfers but with all activities of daily living (ADLs). -She did not document attempt and refusal of two staff to assist the resident with transfers. -She did not notify the resident's primary care physician of the refusal of assistance with ADLs. Interview with Resident #1's primary care physician (PCP) on 05/22/19 at 5:25pm revealed: -The resident had lymphedema and was non-ambulatory. -Resident #3 required extensive assistance with transfers and should receive hands on assistance from facility staff with all transfers. -There was no documentation in their records that showed facility staff notified the PCP that Resident #1 refused the care of two staff with transfers. Interview with the Resident Care Coordinator (RCC) on 05/23/19 at 11:20am revealed: -Resident #1 was "heavy care" and the resident's	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	05/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 9 health was declining. -She was aware Resident #1 care plan assessed the resident as requiring extensive assistance with transfers. -She interpreted the resident's need for extensive assistance by the facility's policy. -The facility's policy says that a resident that needs extensive assistance can do more than 50% of the task for herself. -This means the resident can do a good portion of the transferring herself or maybe one day the resident may need hands on assistance with transferring. -The hands-on assistance with transferring was not needed every day. -There were days when staff assisted Resident #1 by holding onto one of the resident's arms, and the resident used her other arm to hold onto the rail on the wall by the toilet. -When a new staff person was hired the staff learned the needs of all residents' by shadowing trained staff. -The new staff were also to view the residents personal service sheets on the computer to identify the needs of each resident. -She knew Resident #1 had problems with legs but did not consider the resident a fall risk. Interview with the Resident Care Director on 05/22/19 at 4:26pm revealed: -She had worked at the facility since March 2019. -She had observed that Resident #1 was non-ambulatory and required extensive assistance with transfers. -In her opinion the resident had declined health wise and required a lot of staff time. -She was responsible for preparing the care plan but had updated Resident #1's care plan. The facility failed to provide extensive assistance	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	05/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 10 which resulted in a fall and a visit to the emergency room for 1 of 3 sampled residents (Resident #1) The facility's failure to provide hands on assistance with transferring was detrimental to the safety of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/23/19 for this violation. _____ THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 8, 2019.	D 269		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to assure every resident had the right to receive care and services which were adequate, and in compliance with rules and regulations as related to Personal Care and Supervision. The findings are:	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034099	A. BUILDING: _____ B. WING _____	05/23/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 11 Based on interviews, and record reviews, the facility failed to provide personal care assistance based on the assessed care plan for 1 of 3 sampled residents (Resident #1) who required extensive hands-on assistance transfers and toileting which resulted in a fall. [Refer to Tag 0269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)].	D912		