STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092193	A. BUILDING: _____ B. WING _____	R 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(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 follow-up survey on July 23, 2019 through July 24, 2019.	D 000		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination related to a build-up of a black substance on the floor in the dish room, a white residue on the shelves in the walk-in refrigerator, a white residue and brownish substance on the shelves in dry storage area, a black sticky film on the oven and food items stored in the refrigerator and dry storage area that were not dated or labeled. The findings are: Observation of the kitchen and dish area on 07/23/19 at 2:12pm revealed: -There was a build-up of a black substance on the floor in the dish room. -There was a black and brown greasy film on pipes and parts of the wall in the dish area. -There was a buildup of a black substance in the oven. -There were splattered white streaks along the walls, bottom and inside door of the oven.	D 282		

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D 282	Continued From page 1 -There was brownish, black grease buildup on the doors to the oven. -There was a yellow brownish film on the side of the oven and the deep fryer. - There was a yellow greasy film with black debris on the floor between the oven and the deep fryer. Observation of the dry storage area on 07/23/2019 at 2:24pm revealed: -There was a dried white residue and a brownish substance that had accumulated on the shelves. - The containers for oatmeal, grits and cereal were not labeled with an open date. -There were tortilla chips (wrapped in plastic) and unwrapped noodles opened but not labeled and dated. Observation of the walk-in refrigerator on 07/23/19 at 2:48pm revealed: -There was 2 sheet racks of vegetable egg rolls and 2 sheet racks of vanilla pudding scooped into a bowl that were not covered, dated and labeled. -There were 2 trays of individual condiments that were in a container covered with plastic wrap without a label or date. -There were 4 dinner rolls wrapped in plastic without a label and date. -There were 2-12 packs of hamburger buns without labels and dates. -There was 1- 12 pack of hot dog buns, 11 hot dog buns in an opened plastic bag and 1- 3 pack of hot dog buns in an opened plastic bag without labels and dates. -There were 3 packs of salad mix that had been removed from its original box without labels and date. -There was 1 pack of coleslaw mix that had been removed from its original box without a label and date. - There was a white residue on the shelves in the	D 282		

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D 282	Continued From page 2 walk-in refrigerator. Observation of the walk-in freezer on 07/23/19 at 2:57pm revealed: -There was 1 pack of frozen rice without a label and date. -There was an opened bag of sliced carrots that were not wrapped, labeled nor dated. -There was a plastic container of frozen fish fillets without a label and date. Interview with a kitchen staff on 07/24/19 at 10:03am revealed: -"Everything has to be labeled and dated and thrown out in five days." -The food was to be discarded if it was not labeled or dated. -The cooks were the only kitchen staff responsible for labeling and dating food unless a dishwasher was prepping. -The equipment in the kitchen was cleaned daily. -The kitchen staff were not required to sign off on a cleaning schedule. Interview with the Kitchen Manager (KM) on 07/23/19 at 3:11pm revealed: -The kitchen staff were not required to sign off on the cleaning schedule; but were encouraged to do so. -The kitchen staff are "responsible for cleaning their own areas. -The cleaning schedule listed the items that were to be cleaned weekly. -She knew not all the kitchen staff were cleaning their assigned areas. -The dishwashers were responsible for cleaning the dish area. -The cooks were responsible for cleaning their areas. -The kitchen staff is aware to label and date food	D 282		

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D 282	Continued From page 3 items. Interview with the Administrator on 07/23/19 at 3:22pm revealed: -He completed kitchen rounds seven or eight times per day and checked for "drying and washing dishes, chemicals, labels and dates, crumbs, and warming table for cleanliness." -The walk-in refrigerator should be cleaned weekly usually the day before the food delivery came.	D 282		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 5 sampled	D 358		

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D 358	Continued From page 4	D 358		

residents related to an antihypertensive medication (Resident #3).

The findings are:

Review of Resident #3's current FL-2 dated 04/24/19 revealed diagnoses included essential hypertension, acute respiratory failure, chronic-atrial fibrillation, chronic combined systolic and diastolic, acute pericarditis and dementia.

Review of Resident #3's physician's orders dated 06/24/19 revealed:
-There was an order to check blood pressure three times weekly and hold Metoprolol (used to treat high blood pressure) and notify the Primary Care Provider (PCP) for systolic blood pressure less than 100.
-There was an order for Metoprolol 25mg ER take ½ tablet (12.5mg) daily.

Review of Resident #3's June 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check and record blood pressure three times weekly and hold Metoprolol and notify PCP for systolic blood pressure less than 100.
-There was an entry for Metoprolol ER 25mg take ½ tablet (12.5mg) daily.
-There was documentation Resident #3 had a systolic blood pressure of 99 on 06/28/19.
-There was documentation Metoprolol was administered on 06/28/19 at 9:00am.

Observation of Resident #3's medications on hand on 07/23/19 at 4:08pm revealed a bubble pack of Metoprolol ER 25mg available for administration.

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D 358	Continued From page 5 Interview with the Resident Care Director (RCD) on 07/24/19 at 11:02am revealed: -She completed an audit on 07/03/19 and found the medication error dated 06/28/19. -She expected the MA to hold the Metoprolol and notify the PCP based on the parameters. -She had talked to the MA who administered the Metoprolol when it should have been held based on the parameters. Telephone interview on 07/24/19 at 11:29am with a MA revealed: -She took Resident #3's blood pressure per the PCP orders. -She knew Resident #3 had parameters for his blood pressure. -If Resident #3's blood pressure was below the parameter she held his Metoprolol. -She did not recall if she had administered Metoprolol to Resident #3 when his blood pressure was below the parameters set by the PCP on 06/28/19. Interview with the Administrator on 07/24/19 at 11:43am revealed: -He expected the MA to administer medications per PCP orders. -If the order said to hold the medication based on the parameters he expected the medication to be held and to notify the PCP. Attempted interview with Resident #3's PCP on 07/24/19 at 10:01am was unsuccessful.	D 358		