STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010005	A. BUILDING: _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(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 and the Brunswick County Department of Social Services conducted an annual survey on February 9 - 11, 2016.	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 record reviews and interviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs of residents regarding ordered laboratory testing of 1of 5 sampled residents. The findings are: Review of Resident #5's current FL-2 dated 10/27/2015 revealed: -Diagnoses included joint pain, difficulty walking, muscle weakness, and essential hypertension. -Medications included acetaminophen 650 mg given three times per day, Norco 5/325 mg (combination of acetaminophen and a barbiturate) one tablet given every 6 hours as needed for pain, and Mobic 7.5 mg (a nonsteroidal anti-inflammatory drug [NSAID] for pain) given daily. Review of Resident #5's medical record revealed: -Resident #5's Alkaline Phosphatase (blood test used to monitor liver function) test performed on 01/07/2016 was 295 U/L (results greater than	D 273		

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D 273	Continued From page 1	D 273		

101 U/L was considered elevated).
-A repeat blood test was ordered for the week of 01/10/2016.
-The only blood test found performed after 01/07/2016 was a Complete Blood Count (used to measure the quantity of the different types of blood cells) performed on 02/08/2016.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 02/10/2016 at 4:07 pm revealed:
-Resident #5's Alkaline Phosphatase test results on 01/07/2016 was much higher than the previous test performed 12/04/2015 (88 U/L compared to 295 U/L).
-The PCP ordered a repeat Alkaline Phosphatase test to be performed the week of 01/10/2016.
-The PCP could not locate the results of an Alkaline Phosphatase test performed during the week of 01/10/2016.
-The PCP could not recall being notified that Resident #5 refused laboratory testing.
-The PCP stated that she would send an order to the facility requesting the laboratory test today.

Interview with the Resident Care Coordinator (RCC) on 02/11/2016 at 11:55 am revealed:
-Appointments for medical care and laboratory testing are made by the transportation manager once she is given the information by either the RCC or the Registered Nurse (RN).
-The appointment is recorded on the calendar which is kept in the RCC/RN's office.
-Resident #5 had an appointment for laboratory testing on 01/14/2016 but she refused to go.
-The appointment was observed on the calendar but no information about Resident #5 refusal was noted.
-The RCC did not notify the PCP that Resident #5 refused the laboratory test.

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D 273	Continued From page 2 -The Transportation Manager did not reschedule the appointment. The Transportation Manager was not available for an interview.	D 273		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure the primary care provider (PCP) orders were clarified for 1 of 5 sampled residents (#5) resulting in the continuation of a medication that the PCP ordered discontinued. The findings are: Review of Resident #5's current FL-2 dated 10/27/2015 revealed: -Diagnoses included joint pain, difficulty walking, muscle weakness, and essential hypertension. -The Resident was semi-ambulatory with the use	D 344		

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D 344	Continued From page 3 of a wheelchair. Review of the PCP's orders revealed an order dated 12/28/2015 for Mobic 7.5mg by mouth daily for 30 days (Mobic is a medication that is used to relieve pain and inflammation). Review of Resident #5's December 2015 Medication Administration Record (MAR) revealed: - Mobic 7.5mg take 1 tablet every day by mouth had been transcribed on the MAR. -Resident #5 was documented as receiving Mobic 7.5 mg from 12/29/2015 through 12/31/2015. Review of Resident #5's January 2016 MAR revealed: -Resident #5 was documented receiving Mobic 7.5 mg for thirty days in January 2016. -Documentation on the MAR indicated that 1 dose was not given because the resident was away from the facility. -Per the PCP's order the last dose should have been given on 01/27/2016 for a total of 30 doses. Review of Resident #5's February 2016 MAR revealed that Mobic 7.5mg was continued until 02/10/2016 with 1 dose refused on 02/05/2016. Review of documentation on MARS, Resident #5 received 41 total doses of Mobic 7.5mg. Telephone interview with Resident #5's PCP on 02/11/2016 revealed: -The PCP had ordered Resident #5 to take Mobic for 30 days to treat acute pain. -The PCP stated that Mobic can cause problems with long term use particularly in the elderly. - The PCP will plan to see Resident #5 on 02/19/2016 at the facility.	D 344		

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D 344	Continued From page 4 Review of the quarterly pharmacy review dated 01/15/2016 revealed verification for the Mobic order as Mobic 7.5mg to be given 30 days. Communication from the facility's pharmaceutical provider dated 02/10/2016 at 3:15 pm revealed: -The Mobic was not discontinued because it was usually ordered for more than 30 days. -The PCP order was not interpreted as discontinue after 30 days. -The pharmacy will contact the PCP or facility to clarify medication orders that include a number of days to be given or has an end date. Interview with the facility's Resident Care Coordinator (RCC) on 02/11/16 at 11:25 revealed: -The PCP's order for Mobic was received and faxed to the pharmacy on 12/28/2015. -The order was transcribed to the MAR by the pharmacy on 12/28/2015. -Once the order appeared on the MAR, the facility's nurse would compare the PCP's order to the MAR. Interview with the Regional Resident Care Director on 02/11/2016 at 8:40 am revealed the facility's nurse was responsible for verifying the MAR to physician's orders.	D 344		
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	D 358		

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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 record reviews and interviews, the facility failed to assure medications were administered in accordance with the orders of the licensed health care provider for 2 of 6 residents sampled (#2, #6) for Digoxin, which was administered outside of the vital sign parameters ordered by the provider.

The findings are:

1. Review of Resident #6's current FL-2 dated 08/10/15 revealed:
-Diagnoses included atrial fibrillation, dementia, hypertension, and anemia.
-There was an order for Digoxin 0.125mg daily; hold for pulse below 60 beats per minute (bpm). (Digoxin is a medication used to treat abnormal heart rhythms).

Review of the Physician's Order Sheet dated 09/25/15 revealed there was an order for Digoxin 0.125mg daily; hold for pulse less than 60.

Review of Resident #6's November 2015 Electronic Medication Administration Records (EMARs) revealed:
-There was an entry for Digoxin 0.125mg daily; "hold if pulse is below 60."
-On 11/07/15, Digoxin was "Held per MD order parameter"; the pulse was documented as 62 bpm.
-On 11/08/15, Digoxin was "Held per MD order parameter"; the pulse was documented as 64 bpm.
-On 11/21/15, Digoxin was documented as

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administered to Resident #6; the pulse was documented as 50 bpm.
-On 11/26/15, Digoxin was documented as administered to Resident #6; the pulse was documented as 58 bpm.

Review of Resident #6's December 2015 EMARs revealed:
-There was an entry for Digoxin 0.125mg daily; "hold if pulse is below 60."
-On 12/07/15, Digoxin was documented as administered to Resident #6; there was no pulse documented.

Review of the "Consultant Pharmacist's Medication Regimen Review" for Resident #6 dated 10/13/15 revealed:
-"Digoxin should have been held on 08/01/15, but was given. Please review and educate staff."
-Beside the Pharmacist's recommendation there was a handwritten entry in the "Follow- Through" column: "staff educated."
-The entry in the "Follow-Through" column was signed with the Resident Care Coordinator's (RCC) initials and dated 10/30/15.

Review of the "Consultant Pharmacist's Medication Regimen Review" for Resident #6 dated 01/14/16 revealed:
-"Digoxin should have been held on the following dates but was given: 10/16, 10/25, 11/21, 11/27 " (2015).
-"On 11/7 and 11/8 (2015) Digoxin was held but it should have been given."
-"On 12/7 (2015), there is no heart rate recorded for Digoxin."
-In the "Follow-Through" column there was a handwritten entry "staff educated " signed with the RCC's initials and dated 01/21/16.

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D 358	Continued From page 7 Telephone interview with Resident #6's Certified Family Nurse Practitioner (FNP-C) on 02/11/15 at 10:31am revealed: -The facility faxed Resident #6's vital sign report to the FNP-C monthly. -The FNP-C expected Digoxin to be administered in accordance with the parameters written on the order. -Digoxin should have been administered to Resident #6 when the pulse was 62 bpm and 64 bpm. -Digoxin should not have been administered to Resident #6 when the pulse was 50 bpm. -The FNP-C expected the pulse to be checked before Digoxin was administered. -The FNP-C had not been notified by the facility of any medication administration errors for Resident #6. -The FNP-C expected to be notified by the facility of any medication errors but thought the facility "most likely" did not recognize the errors. -The medication errors did not cause danger to Resident #6 if she did not have changes in her pulse when the errors occurred. Interview with the Registered Nurse/ Director of Clinical Services and Executive Director on 02/11/16 at 10:23am revealed: -Digoxin was administered to Resident #6 two times in November 2015 when it should have been held. -Digoxin was held two times in November 2015 when it should have been administered. -It was unknown why there was no pulse documented on 12/07/15 because the facility's computerized medication administration system would not allow the Medication Aide (MA) to sign off the medication as being administered without documenting the pulse. -The Registered Nurse/ Director of Clinical	D 358		

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D 358	Continued From page 8 Services would check to see if there was problem with the computer medication administration system. -All MAs would be retrained. Interview with the Regional Director on 02/11/16 at 11:35am revealed: -Training on the "6 Rights" of medication administration had been initiated that morning (02/11/16). -All MAs would be retrained. 2. Review of Resident #2's current FL-2 dated 11/11/2015 revealed: -Diagnoses included atrial fibrillation, dementia, congestive heart failure, hypertension, stroke, diabetes mellitus type II, hyperlipidemia, neuropathy, and arthritis. -A physician's order for Digoxin (used to lower the heart rate) 0.125mg daily (hold if pulse less than 60). Review of Resident #2's January 2016 Medication Administration Records (MARS) revealed: -There was an entry for Digoxin 0.125mg tablet take one daily "hold if pulse less than 60". -A Medication Aide (MA) documented administration of Digoxin 0.125mg on 01/10/2016 at 9:30am when Resident #2's pulse was documented as 59. Interview with a Medication Aide (MA) on 02/11/2016 at 10:35am revealed: -When she administered Digoxin to a resident, she checked the resident's pulse for one minute and if the pulse was less than 60, the digoxin was held. -Resident #2 got Digoxin in the morning.	D 358		

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D 358	Continued From page 9 -The MA did not recall ever having to hold the Digoxin for Resident #2, "she's usually good". -The MA remembered one time holding the Digoxin for another resident [resident named]. Review of the Consultant Pharmacist's Medication Regimen Review for Resident #2 dated 01/01/16 and 01/18/16 revealed the following documentation: -"Digoxin should have been held on 11/17 but was given". -"Staff educated 01/21/16". Interview with the Executive Director (ED) on 02/11/2016 at 8:00am revealed: -The ED was not aware of any errors with medication administration of Digoxin. -The ED talked to the staff on the evening of 02/10/2016 who documented administration of the Digoxin to Resident #2 on 01/10/2016 and the staff person stated she checked the pulse and if the pulse was less than 60, she would not give the Digoxin. Interview with the Regional Director on 02/11/2016 at 11:35am revealed: -Training on the "six rights" of medication administration had been initiated with the medication aides. -All medication aides would be retrained. Based on observation of Resident #2 who resided in the Special Care Unit of the facility, the resident was not interviewable. Resident #2's physician was not available for interview.	D 358		

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D912	Continued From page 10	D912		
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 observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to adult care home medication aides training and competency evaluation requirements. The findings are: Based on observation, interviews, and record review, the facility failed to assure 1 of 5 staff (Staff A) met the qualifications and requirements to perform medication aide duties and administer medications. [Refer to Tag D935 G.S. 131D 4.5B(b) Adult Care Home Med Aide Training and Competency (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.	D935		

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D935	Continued From page 11 (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.	D935		

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D935	Continued From page 12 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 1 of 5 Medication Aides (Staff A), hired after October 2013, who administered medications, had passed the medication written examination within 60 days of completing the medication clinical skills validation. The findings are: Review of Staff A's personnel file revealed: -Staff A was hired on 08/18/2015 as a Personal Care Aide. -Staff A's position was changed to Medication Aide on 10/18/2015. -A medication clinical skills checklist validation was completed for Staff A on 10/16/2015. -There was no documentation for Staff A having taken or successfully completing the medication aide test. Review of a residents' December 2015 medication administration records (MARS) revealed Staff A documented administration of medications on 12/17/2015, 12/20/2015, 12/23/2015, 12/26/2015, 12/28/2016, and 12/31/2015. Review of a residents' January 2016 medication administration records (MARS) revealed: -Staff A documented administration of medications on 01/02/2016, 01/03/2016, 01/10/2016, 01/17/2016, 01/19/2016, 01/23/2016, 01/24/2016, 01/26/2016, and 01/31/2016. -Staff A documented administration of Lanoxin (a medication used to lower the heart rate) to a	D935		

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resident with a pulse of 59 when there were physician parameters to hold the Lanoxin if pulse less than 60.

Review of a residents' February 2016 medication administration records (MARS) revealed Staff A documented administration of medications on 02/06/2016, 02/07/2016, and 02/09/2016.

Observations of Staff A on 02/09/2016 between 11:50am and 11:54am revealed Staff A administered insulin to Resident #2 using as follows:
-Staff A rolled Resident #2 in her wheelchair from the dining room of the Special Care Unit to her room.
-Staff A cleansed her hands with hand sanitizer then donned disposable gloves.
-Staff A administered 25 units of insulin subcutaneously to Resident #2 at 11:53am using aseptic technique.
-Staff A disposed of the needle in the sharps container.
-Staff A removed her disposable gloves and placed the used gloves in the trash receptacle.
-Staff A cleansed her hands a second time with hand sanitizer after removing and disposing of her gloves.

Interview with Staff A on 02/11/2016 at 10:35am revealed:
-She had been a Medication Aide (MA) for "three to four months".
-She was taken off the medication cart as of 02/10/2016 because she had not taken the state medication aide test.
-She was supposed to take the med aide test in January 2016 but did not due to a family issue.
-She had been administering medications at the facility for "about three months".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010005	A. BUILDING: _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(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
D935	Continued From page 14 Interview with the Resident Care Coordinator (RCC) on 02/10/2016 at 4:15pm revealed: -She was responsible for ensuring documentation of med aide testing certification was in the facility and staff in the front office filed the information in staff personnel files. -She thought Staff A had passed the state medication aide test. -Staff A had been scheduled to take the state medication aide test. -She was not sure of the dates Staff A was supposed to take the medication aide test. -She was not sure if Staff A had notified the facility that she did not take the medication aide test when scheduled. -Staff A had been administering medications after the 60 day timeframe from the date of Staff A's medication clinical skills checklist validation completed on October 16, 2015. Interview with the Executive Director on 02/11/2016 at 8:00am revealed: -She was not aware until 02/10/2016 that Staff A had not taken and passed the state medication aide test. -She was not aware of any errors Staff A had made with the administration of Lanoxin. -The Resident Care Coordinator (RCC) was responsible for ensuring staff had completed and passed the medication aide testing within the required timeframe. -She would be monitoring staff training closer. Review of documentation received from the facility Regional Director on 02/11/2016 revealed: -Staff A was removed from the medication administration responsibility on 02/10/2016. -Staff A had been scheduled for the medication	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010005	A. BUILDING: _____ B. WING _____	02/11/2016

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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
D935	Continued From page 15 aide test on March 3, 2016. -Staff A would also be required to repeat the medication competency training. _____ Review of the Plan of Protection submitted by the facility on 02/11/2016 revealed: -The employee who had not secured their Medication Administration Certification by taking the NC Med Test within 60 days was removed from the cart immediately upon knowledge of the oversight. -The facility will ensure compliance with all required training requirements for all medications aides. -The facility will ensure all medication aides have successfully completed any and all medication administration training and has passed the NC med test within the required 60 day time frame. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 27, 2016.	D935		