STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
				A. BUILDING:			
		HAL05501	1	B. WING		05/1	1/2016
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF I	LINCOLNTON		I CHURCH RO ON, NC 28092			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIE		ID	PROVIDER'S PLAN OF CORRECTION	N.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDE SC IDENTIFYING INF	D BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETE DATE
D 000	Initial Comments			D 000			
	The Adult Care Licens County Department o an annual survey on I	f Social Services	conducted				
D 079	10A NCAC 13F .0306 Furnishings	(a)(5) Housekee	ping and	D 079			
	10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities.						
	This Rule is not met	as evidenced by:					
	Based on observation failed to prevent the u electric outlet adapter resident rooms (Room	se of non-surge s in 3 of 39 occu	protected pied				
	The findings are:						
	Observation on 5/10/revealed: -A six plug electric ou outlet next to the bed, itOne of the plugs was surge protector, into we phone charger and ar space heater was off) -One of the plugs was (off).	tlet adapter, loca with 4 devices p white and came which was plugge n oil-filled space l	ated in the blugged into e from a led in a cell heater (the				

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SU COMPLET			
		HAL0550 ⁻	11	B. WING		05/11	/2016
	/IDER OR SUPPLIER SSISTED LIVING OF I	LINCOLNTON	440 SALEN	RESS, CITY, STA I CHURCH RO ON, NC 28092	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING IN	ENCIES ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICE TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	D BE	(X5) COMPLETE DATE
- Abb-1-no Ore - Astrono Ore - Astrono Ore - Astrono Ore - Astrono - Indiana	continued From page of black plug came from edside table (off). The source of the found of determined. Severation on 5/10/2 evealed: A three outlet electricated with a table lample. Severation on 5/10/2 evealed: A three outlet adapte the resident's bed. Into the adapter was sumidifier and a hearing from the free wall outlined and the free wall outlined and the free wall outlined and the free was using the lephone interview of the had been in his page. The had been in his page of the was shared between the each week, alter the did not provide an uring orientation other each week, alter the did not provide and the would expect the executive Assistant to the him.	om a small fan ourth plug (black of at 10:45AM of adapter behind p plugged into a plugged into a plugged a nighting aid device. Unidifier were betwas plugged swith one reside brought in the edge. With the Mainten 2:20PM reveal osition for three een this facility and 3 darnating each weny safety traininger than address he wheelchair lift maintaining a scare unit. Resident Care	in color) was of Room A-1 I a bedside It and turned of Room B-9 In outlet near clight, a oth turned a cell phone ent revealed electric outlet ance ed: weeks. and a "sister" rys at the leck. g to staff ing fire drills, it in the ecured Director or	D 079			

Division of Health Service Regulation

STATE FORM 6899 RKKZ11 If continuation sheet 2 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
7.11.01 27.11 01 001.			A. BUILDING: _		00.000		
		HAL05501	1	B. WING		05/1	1/2016
NAME OF PROVIDE	ER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARILLON ASS	ISTED LIVING OF I	LINCOLNTON		I CHURCH RO ON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICI Y MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
-The anyth -Resulve provided p	e facility has had I hably did not know sidered hazards. The facility dated 8 heck mark next to the facility dated 8 heck mark next to the facility dated 8 heck mark next to the facility mark next to the facility management of Protection valued:	se outlet adapter should be a sure members were not to only use sure say who in the fections). Medication Aide ekeepers knew is if they were four excutive Director excises on 5/10/1 to be "UL [Unde" and extension when what they could be suffered in the outlet adapters would in the category of executive Director in good" for the category of executive in the cate	ge protector. told to not urge facility es, Personal to report the and the 6 at 4:00PM rwriter's cords were do in their ever and sters were etion report category of "proper use 5/10/16 and be removed the day on frequent hazardous in company	D 079			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		UAL 055044		B. WING		05/44/0046
		HAL055011				05/11/2016
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CARILLOI	N ASSISTED LIVING OF I	LINCOLNTON		/I CHURCH RO ON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLET
D 079	Continued From page	e 3		D 079		
	THE CORRECTION I VIOLATION SHALL N 2016.					
D 108	10A NCAC 13F .0311	(b)(2) Other Requirer	ments	D 108		
	10A NCAC 13F .0311 (b) There shall be a harmonistain 75 degrees winter design condition following shall apply trappliances. (2) Unvented fuel burportable electric heater This rule apply to new	neating system suffici F (24 degrees C) und ons. In addition, the to heaters and cooking rning room heaters ar ers are prohibited.	er g nd			
	This Rule is not met	as evidenced by:				
	Based on observation failed to prevent the usual 39 occupied resident A-9, A-12, A-15, B-2, D-4, D-7 and D-15).	use of space heaters in rooms (Rooms A-1, A	n 14 of \-2,			
	The findings are:					
	Observation on 5/10/ A-12 (unoccupied) respace heater, unpluge	vealed an oil-filled rac	diator			
	Observation on 5/10/revealed: -A small radiant space sitting on top of the he under the windowThis space heater wa	e heater with a fan (o eater/air conditioning	ff), unit			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE Co			E SURVEY PLETED	
		HAL055011	B. WING		0	5/11/2016
	ROVIDER OR SUPPLIER N ASSISTED LIVING OF	LINCOLNTON 440 SAI	ADDRESS, CITY, STATE LEM CHURCH ROAI .NTON, NC 28092	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 108	surge protector that wall outlet. -A small desk lamp (a surge protector. Observation on 5/10/revealed: -A small radiant space sitting on top of plasting a six outlet adapter wards a six outlet adapter wards a six outlet adapter wards and the floor by observation on 5/10/revealed an oil-filled room. Observation on 5/10/revealed an oil-filled radiator shear the bedroom double the special control of the speci	vas plugged directly into a also off) was plugged into the 16 at 10:45AM of Room A-1 e heater with a fan (off), c drawers and plugged into ith no surge protection. e heater with a fan (off), the door. 16 at 11:00AM of Room B-7 radiator space heater in the 16 at 11:30AM of Room are unit revealed: space heater on the floor or. In outlet and turned on. resident who occupied 16 at 11:30AM revealed: person, place, and time. If or staff to assist him with a ter was on to warm the 16 at 1:58PM of the ealed: e permitted viewing of the y.	D 108			

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STATE FORM 6899 RKKZ11 If continuation sheet 5 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		-n. l `		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL055011	В	B. WING		05/11/2016
	ROVIDER OR SUPPLIER N ASSISTED LIVING OF	LINCOLNTON	STREET ADDRES 440 SALEM C LINCOLNTON	HURCH RO	AD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 108	outlet next to her bed-One of the plugs into surge protector, into a phone charger and a heater (off). Observation on 5/10/revealed an oil-filled plugged into the wall Observation on 5/10/revealed an oil-filled corner of the room (off). Observation on 5/10/revealed an oil-filled foot of the resident's Observation on 5/10/revealed an oil-filled bathroom, partially procounter and not plugged in (off). Observation on 5/10/revealed an oil-filled plugged in (off). Observation on 5/10/revealed an oil-filled a recliner and not plugged in (off). Observation on 5/10/revealed an oil-filled plugged in (off). Observation on 5/10/revealed an oil-filled plugged in (off).	et adapter, located in the land of the adapter came from which was plugged in a moil-filled radiator space. The at 2:05PM of Room Endiator space heater, from under a desk (off). The at 2:15PM of Room Endiator space heater in the at 2:20PM of Room Endiator space heater at bed, plugged in (off). The at 2:32PM of Room Endiator space heater in ushed under the vanity ged in. The at 2:56PM of Room Endiator space heater, and at 2:57PM of Room Endiator space heater, and at 2:57PM of Room Endiator space heater be gged in.	e a cell e A-15 A-15 A-15 A-15 Chind D-3	D 108		

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DIVISION OF FIGURE REGULATION					1		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2)	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	A. BUILDING:			=1ED
		HAL055011	B. W	VING		05/1	1/2016
NAME OF PR	ROVIDER OR SUPPLIER	ST	REET ADDRESS,	, CITY, STAT	E, ZIP CODE		
			IO SALEM CHU				
CARILLON	N ASSISTED LIVING OF I	LINCOLNTON	NCOLNTON, N				
040.15	SLIMMADV STA	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	1	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	_P	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	'	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
D 108	Continued From page	e 6	D.	108			
	Confidential interview	s with 13 residents					
	revealed:						
	-Staff had provided or	ne resident with a space					
	heater but it had not b						
	-In the winter, one res	sident used a space heate	r				
	because the "thermos	stat" was broken in the wa	II				
	heater/air conditioning	g unit, which he had spoke	en				
	to the "Maintenance N	Man" concerning.					
	-One family member v	was supposed to take bac	k				
	a space heater no lon	nger being used.					
	-One resident used he	er space heater when it wa	as				
	cold in the morning.						
	-One resident stated t	the wall heater/air					
	conditioning unit "doe	esn't work for heat," he use	ed				
	the space heater at ni	ight on a low setting, he sl	nut				
	it off every time he lef	t his room and "I'm afraid					
	the space heater migh						
	-One resident did not	have a space heater					
	<u> </u>	n but used one during the					
	winter.						
		it "got pretty cold in the					
		n't think the window heate	r				
	works anymore."						
		ecently" a space heater of	1				
	cold days "just to know						
		space heater before she go					
		ich was used in the winter					
	-	as the roommate thought					
	the room was too war						
		they did not use the space					
		out a roommate did use it.					
		they used a space heater	ın				
	the winter.	than and a green best					
		they used a space heater					
		he room got chilly without	π				
	but they never left it o	* ·					
		space heater when it got	_				
		ting/air conditioning unit di					
ı	TIOT WORK SHO CHE WAS	" Amit ant lie" tateaws e a	1				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
		HAL055011	B. WING		05/11/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, S	STATE, ZIP CODE	
CARILLO	N ASSISTED LIVING OI	LINCOLNTON	440 SALEM CHURCH I		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU R LSC IDENTIFYING INFORMATION	ID LL PREFIX	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE COMPLETE O THE APPROPRIATE DATE
D 108	on the Special Care -Hazards in rooms i walkers and wheelc bathroomsConcerning space have them, I think" a room was probably Confidential intervie Care Aide on the As facility revealed she nothing near the res Telephone interview Director on 5/10/16 -He had been in his -He was shared bet facility, 2 days at on other each week, al -He did not provide during orientation of alarm resets, use of transport vehicle an setting for the speci -He would expect th Executive Assistant to himSpace heaters cou living side of the faci unitUse of space heate the county the facilit -The window heatin provided heat throug them, which was sh valve under each ur -The facility started	w with a Personal Care A Unit revealed: Included oxygen tubing, hairs and blow dryers in theaters, "they [residents] and the one in Resident # "not safe." w with a second Personal sisted Living side of the always made sure there idents heaters. with the Maintenance at 2:20PM revealed: position for three weeks. ween this facility and a "see facility and 3 days at the ternating each week. any safety training to staft her than addressing fire the wheelchair lift in the different maintaining a secured all care unit. Resident Care Director to report any safety conditions the said of the sa	d care d on gh		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	COMPLETED
HAL055011 B. WING	05/11/2016
NAME OF PROVIDER OR SUPPLIER CARILLON ASSISTED LIVING OF LINCOLNTON STREET ADDRESS, CITY, STATE, ZIP CODE 440 SALEM CHURCH ROAD LINCOLNTON, NC 28092	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (X4) ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD PREFIX CROSS-REFERENCED TO THE APPRODE	ULD BE COMPLETE
D 108 -When the heating/air conditioning units were "turned over" was based on resident preferenceResidents used space heaters at night because it was cooler then, but he was not sure if the heating/air conditioning units in these rooms had been turned over yet. Interview with the Executive Director and the Director of Clinical Services on 5/10/16 at 4:00PM revealed: -The facility had been open since 2008 and there was not a written policy regarding the use of space heaters. -The heating/air conditioning units in the rooms did not put out sufficient heat during cold periods and the facility obtained the safest space heatersOnly oil-filled space heaters were used. Review of the most current fire inspection report for the facility dated 8/5/15 revealed no check mark next to the category of "portable unvented heaters." Attempted telephone interview with the Fire Marshall on 5/11/16 at 12:20PM was unsuccessful. A Plan of Protection was provided on 5/10/16 and included: -All space heaters would be removed by facility management by the end of the day on 5/10/16Facility management would perform frequent inspections of all rooms to ensure no space heaters were presentFacility staff would receive training on company policy regarding space heaters not to be allowed in the facility. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 25,	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL055011	B. WING		05/11/2016
	ROVIDER OR SUPPLIER	LINCOLNTON 440 SAI	ADDRESS, CITY, STA LEM CHURCH RO .NTON, NC 28092	AD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 108	Continued From page 2016.	9	D 108		
D912	G.S. 131D-21 Declar Every resident shall h 2. To receive care an adequate, appropriate	aration of Residents' Rights ation of Residents' Rights ave the following rights: d services which are e, and in compliance with tate laws and rules and	D912		
	review, the facility fail- received care and ser appropriate and in con- state laws and rules a housekeeping and fur non-surge protected e	as evidenced by: a, interview and record ed to assure residents vices that are adequate, mpliance with federal and and regulations related to mishings (use of hazardous electric outlet adapters) and se of space heaters which			
	facility failed to preven protected electric outl occupied resident roo B-9)[Refer to Tag 079 (5), Housekeeping an Violation)].	tions and interviews, the nt the use of non-surge et adapters in 3 of 39 ms (Rooms A-1, A-9 and , 10A NCAC 13F .0306(a) d Furnishings (Type B tion and interviews, the nt the use of space heaters			
	in 14 of 39 occupied r A-2, A-9, A-12, A-15,	esident rooms (Rooms A-1, B-2, B-7, B-10, C-14, D-2, I5)[Refer to Tag 108, 10A			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		HAL055011	B. WING		05/	/11/2016
NAME OF P	ROVIDER OR SUPPLIER		T ADDRESS, CITY, STA			
CARILLO	N ASSISTED LIVING OF I	INCOLNION	ALEM CHURCH RO DLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
D912	1 0	e 10 2), Other Requirements	D912			

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