STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	R-C 12/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

(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 Wake County Human Services conducted a follow-up survey and a complaint investigation on 12/19/17, 12/20/17 and 12/21/17.	{D 000}		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews the facility failed to assure 1 of 5 (#2) sampled residents with a history of falls received proper supervision based on the assessed needs. The findings are: Review of Resident #2's current FL-2 dated 9/12/17 revealed: - Diagnoses included Alzheimer's disease, anxiety disorder, atherosclerotic heart disease, localized edema, unsteady on feet and vitamin D deficiency. - An physician order for foam hip protection garments. - Resident #2 was ambulatory and non-verbal. - Resident #2's level of care was indicated as domiciliary, and secure unit/hospice. Review of Resident #2's care plan dated 9/12/17	D 270		

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revealed:
- Resident #2 required hands on assistance when transferring for safety.
- Resident #2 required hands on assistance for ambulation.
- Resident #2 required a person to walk with her for safety.
- Resident #2 required guidance to destinations for safety.
- Resident #2 was assessed to be a wanderer.
- Resident #2 was assessed to be totally dependent related to toileting, bathing, and personal hygiene.

Review of the facility fall intervention protocol revealed:
- The protocol indicated that residents with a higher pattern of falls than normal would have measures implemented.
- There were three different levels indicated by the protocol for falls.
- Each level was determined based on number of falls and pattern of falls.
- The indicator for using the protocol was two or more falls in one week, three or more falls in one month, or four or more falls in three months.
- If a resident met any of the indicators above, the resident was considered a new onset.
- For new onset, the level one fall protocol was implemented for residents.

Review of Resident #2's physician orders revealed:
- A physician order dated 9/12/17 to continue high falls precautions.
- A physician order dated 9/12/17 for referral to Hospice due to failure to thrive and recent decline/debility.
- Subsequent physician orders for falls precautions were written on 10/10/17 and

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D 270	Continued From page 2 11/20/17. - The subsequent physician orders were written as falls precautions without the word "high". - The physician orders for falls precautions do not specify any falls prevention options. - There was not an order for a chair or bed alarm. - There was not an order for a high back chair. Review of Resident #2's accident/incident report for 9/4/17 revealed: - The responsible person and the physician were notified. - The resident fell at 3:00 P.M. when she tried to walk unassisted. - The resident fell on her buttocks. - The resident had no injuries or complaints of pain. - The accident/incident report was not signed by the Resident Care Director (RCD). - The staff would continue to monitor and assist the resident. Review of Resident #2's accident/incident report for 9/11/17 revealed: - The responsible person and the physician were notified. - The resident fell at 4:10 P.M. when she tried to stand unassisted and tripped over the leg of her chair. - The resident had skin tear on the left elbow that reopened as a result of fall on 9/11/17. - The staff would continue to monitor and assist the resident. Review of Resident #2's accident/incident report for 9/17/17 revealed: - The responsible person and the physician were notified after the fall. - The accident/incident reports were not signed by the RCD for 9/17/17.	D 270		

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- The resident fell at 3:15 P.M. when she walked in the dining room.
- The accident/incident report did not indicate if the resident was alone when she walked on 9/17/17.
- When the resident fell, she hit a door.
- The resident had no bruises or complaints of pain.
- The staff would continue to monitor the resident.

Review of Resident #2's accident/incident report for 10/16/17 revealed:
- The responsible person and the physician were notified after the fall.
- The resident and staff member fell at 2:20 P.M. when the staff tried to stop the resident from falling.
- There were no injuries reported for this fall.
- Hospice was notified after the fall.

Review of Resident #2's accident/incident report for 12/6/17 revealed:
- The responsible person and the physician were notified after the fall.
- The resident fell at 2:00 P.M. when she walked to her bathroom from her chair where staff was assisting another resident.
- She was transported to the hospital.
- The fall resulted in a injury to Resident #2's head with sutures placed.
- Hospice was notified after the fall.

Review of Resident #2's accident/incident report for 12/13/17 revealed:
- The responsible person and the physician were notified after the fall.
- The resident fell at 5:00 P.M. when she tried to walk and loss balance.
- The accident/incident report does not indicate if resident was alone nor the location of fall.

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- The resident had a skin tear on her right elbow as a result of the fall.
- The skin tear was cleaned and bandaged.
- The staff would continue to monitor and assist the resident.

Review of Resident #2's progress note dated 9/22/17 revealed:
- Resident #2 was found on the floor by her bathroom wrapped in a blanket at 8:50 A.M.
- Resident #2 had no complaint of pain.
- The responsible person and the physician were notified.
- The staff would continue to monitor the resident.

Review of Resident #2's progress note dated 10/8/17 revealed:
- Resident #2 missed the chair and fell on the floor of the dining room at 7:00 P.M.
- The resident did not have any injuries.
- The responsible person and the physician were notified.
- The staff would continue to monitor.

Review of Resident #2's progress note dated 11/12/17 revealed:
- The "med tech" notified a staff member identified in the note as the Supervisor of Resident #2 falling.
- The responsible person and the physician were notified.

Interview with Hospice Nurse on 12/20/17 at 9:07 A.M. revealed:
- She came to the facility once a week to see Resident #2.
- Resident #2 was admitted to Hospice services on 10/5/17 based on physician order/referral.
- Resident #2 had fallen several times since her admission.

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- She made a visit to the facility on 12/6/17, prior to Resident #2's fall.
- She saw Resident #2 on 12/6/17 in the dining room sitting alone in her high back chair.
- She was concerned due to her history of falls.
- She asked the medication aide why the resident was in the dining room alone and that she does not need to sit alone because of her history of falls.
- She spoke with the Resident Care Coordinator (RCC) about finding Resident #2 sitting alone.
- She knew Resident #2 was a risk for falls.
- The RCC thanked her for making her aware and that she would take care of it.
- Another Hospice nurse called her 15 minutes after she left the facility and made her aware that Resident #2 fell.
- Resident #2 fell trying to walk to the bathroom.
- Resident #2 had a injury to her head and 911 was called.
- She spoke with the nurse at the Emergency Room and was told that staples were placed in Resident #2's scalp.

Interview with a first shift Personal Care Aide (PCA) on 12/19/17 at 10:35 A.M. revealed:
- She worked for the facility for 6 months.
- The staff checked residents in the memory care unit once an hour.
- The staff documented the care completed on the Personal Care logs.

Interview with primary RCC on 12/20/17 at 11:10 A.M. revealed:
- She had worked at the facility longer than the current RCD, the Assistant Resident Care Director (ARCD) and the Administrator.
- The facility had a falls policy, falls assessment, and falls risk assessment.
- For falls precautions, the facility tried to perform

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more frequent checks on the resident, or get them an alarm for the chair or bed.
- The staff checked the residents every hour.
- For falls precautions, residents would be checked every 15 to 30 minutes.
- Staff relayed information in the daily "crossover" or change of shift about residents with special needs.
- Information about residents on falls precautions could be found in the 24 hour book.
- Resident #2 was ambulatory and frequently fell.
- Resident #2 had an order for hip protectors, alarms and a special type of chair.
- Resident #2 was kept near the front of the unit or in the living room area when out of bed.

Interview with first shift Medication Aide (MA) on 12/20/17 at 12:20 P.M. revealed:
- Information about falls precautions would be in the "big black book".
- The information concerning falls precautions may also be on the electronic medication administration records (eMARs).
- The MAs told the PCAs about new or changed orders related to care needs.
- Sometimes the PCAs told the MAs updated information about a resident, if they were off for a few days.
- The staff knew Resident #2 and that she had fallen previously.
- She did not know of any new orders for Resident #2 for increased or changed supervision.

Interview with a first shift PCA on 12/20/17 at 8:30 A.M. and 1:40 P.M. revealed:
- Resident #2's staples were removed from the scalp area.
- Resident #2 had staples to the scalp because she had fallen.

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D 270	Continued From page 7 - Resident #2 attempted to walk from her chair on her own. - Resident #2 would walk with her eyes closed. - Resident #2 stayed near the front of the unit in her chair when out of bed. - Resident #2 needed assistance when walking in hallway and when walking anywhere. Interview with memory care unit RCC on 12/19/17 at 11:10 A.M. revealed: - She had worked for the facility for two weeks. - She described Resident #2 as prone to fall. - Resident #2 fell two weeks ago and obtained staples for a scalp laceration. - Resident #2 fell while attempting to walk to the bathroom in her room. - She had not made any changes regarding Resident #2 supervision after the fall. - She had spoken with the staff member present at the time of the fall. - She was not aware of any new orders or changes in supervision after the fall. Interview with another first shift PCA on 12/20/17 at 12:25 P.M. revealed: - She believed falls precautions meant when "stuff was in the way and hindered the residents' path." - The MA would tell the PCA if a resident was on falls precautions. - She was unsure if there were guidelines related to falls precautions. - She knew Resident #2 was a risk for falls. - She knew Resident #2 needed assistance transferring to bed, chair and the bathroom. Interview with the memory care unit RCC on 12/20/17 at 12:45 P.M. revealed: - For falls precautions, she expected a resident would be checked once an hour instead of every	D 270		

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2 hours.
- She did not know what the facility had in place for Resident #2's fall precaution order.
- She was not aware of any other changes made for Resident #2's fall precautions as a result of recent fall.
- She expected each MA to make the other staff members aware of who needed special care.
- Resident #2 did not have a bed or chair alarm.
- Resident #2 was wearing hipsters.
- Resident #2 did not have a mat in her room near her bed.

Review of Resident #2's Personal Care Logs for September 2017, October 2017, November 2017 and December 2017 revealed:
- The personal care log contained a list of routine personal care orders.
- All of Resident #2's assessed needs from the care plan were on the personal logs.
- The order for falls precaution was signed off by staff on three shifts.
- The order appeared on all four months logs.
- The order was dated 8/26/16.
- The order for assistance with ambulation/mobility and guidance for direction was signed off by staff on three shifts.
- The order appeared on the logs for all four months.
- The order was dated 8/26/16.
- The order for assistance with stairs/steps was signed off by staff on three shifts.
- The order appeared on all four months logs.
- The order was dated 8/26/16.
- The order for assistance with bed/chair/toilet transfer hands on as needed was signed off by staff on three shifts.
- The order was dated 8/26/16.
- The order dates of 9/12/17, 10/11/17, and 11/20/17 for falls precautions did not appear on

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any of the personal care logs.
- The date of the most recent care plan 9/12/17 did not appear on any of the personal care logs.

Interview with the primary RCC on 12/20/17 at 4:10 P.M. revealed:
- She supervised the MAs.
- She knew Resident #2 had hip protectors and a special chair to prevent falls.
- She did not know of any changes concerning the falls precautions for Resident #2's after the last fall 12/13/17.
- Residents with orders for falls precautions had their orders noted and transcribed onto the Personal Care Logs by the RCD.
- Staff signed off on the Personal Care Log items.

Interview with Resident Care Director on 12/21/17 at 9:00 A.M. revealed:
- She had worked for the facility for three weeks.
- She was not familiar with the facility's fall guidelines and needed to review them.
- She was not aware of the number of falls that Resident #2 had in the past 3 months.
- She was not aware of Resident #2's scalp lacerations that resulted from falls in August 2017 and December 2017.
- She did not know of any changes concerning Resident #2 for falls precautions after the last fall on 12/13/17.
- She and the ARCD were responsible for transcribing orders to the eMAR and personal care logs.

Interview with Resident #2's Primary Care Provider on 12/21/17 at 11:13 A.M. revealed:
- She was aware of Resident #2's numerous falls.
- The previous RCD had left her a message and asked that she not order "high falls precautions".
- The previous RCD stated that all residents were

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a falls risk.
- She emailed the responsible person for Resident #2 after the 12/6/17 fall because staples were applied to a scalp laceration for the second time within 4 months.
- The first scalp laceration with staples placed happened in August 2017.
- She requested that the staff watch Resident #2 "closely" after the falls.
- Resident #2 walked with her eyes closed.
- She ordered hipsters for Resident #2.
- She had not written any other orders for protective devices.
- Hospice provided the high back chair.

Interview with Resident #2's Primary Care provider on 12/21/17 at 9:50 A.M. revealed:
- She spoke with the responsible person when she began caring for residents at the facility about Resident #2 decreased cognitive state.
- Resident #2 walked with her eyes closed.
- She discussed with the responsible person the possible need for skilled care.
- Responsible person became upset when they discussed the need for skilled care because he felt the facility was home for Resident #2.
- The responsible person requested that Hospice services be tried first.
- She made a recommendation for a need for increased level of care.
- She offered a referral for Hospice services.
- Resident #2 had to be watched all the time and needed extra care.
- Resident #2 was fragile.
- Resident #2 had hip protectors and a scoop mattress had been ordered.
- After the last fall in December, she spoke with the facility again about Resident #2's needs.
- She continued to recommend providing Resident #2 with the "highest care" for her safety.

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D 270	Continued From page 11 - She did not write any new orders after the 12/13/17 fall. Interview with a first shift PCA on 12/21/17 at 1:40 P.M. revealed the MA did not tell her of any changes related to Resident #2's care after the falls. Interview with another first shift PCA on 12/21/17 at 1:45 P.M. revealed the MA did not tell her of any changes related to Resident #2's care after the falls. Interview with third first shift PCA on 12/21/17 at 2:00 P.M. revealed the MA did not tell her of any changes related to Resident #2's care after the falls. Interview with Resident #2's responsible person on 12/21/17 at 1:26 P.M. revealed: - He knew Resident #2 fell frequently. - Resident #2 was a very active person and was still able to walk. - He did not recall an email from the provider concerning the last fall with a scalp laceration. - He had spoken with Hospice concerning Resident #2 and the falls. - The facility had contacted him each time Resident #2 had fallen. - He was aware that Resident #2 was sent to the ER in December 2017 for staples to the scalp. Based on observations, record reviews and interviews of Resident #2, the resident was determined not to be interviewable. The facility failed to provide the level of supervision for a resident with a history of falls, in accordance to the assessed needs of Resident #2 and the facility's fall protocol. The facility's	D 270		

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D 270	Continued From page 12 failure to supervise Resident #2 resulted in nine falls in a three month period with a recent fall in December 2017 that resulted in a scalp laceration that required staples. The failure of the facility was detrimental to her safety and constitutes a Type B Violation. _____ Review of the the facility's Plan of Protection dated 12/21/17 revealed: - Inservice for all staff will be conducted to identify residents at fall risk and communicated to the Resident Care Director (RCD), Assistant Resident Care Director (ARCD) and/or designee by 1/5/18. - Fall intervention and oversight will be implemented by the RCD and or designee and fall protocol will be implemented for safety measures when risk identified and as needed. - The RCD/ARCD will monitor the effectiveness of interventions weekly and make recommendations to the resident's physician. - The community will implement on 12/21/17 weekly monitoring. - Residents identified on fall protocol will stay on the list for weekly monitoring until improvement is identified by the clinical team - RCD/ARCD. - The physician will be notified if additional interventions are recommended and/or if the resident needs an evaluation for higher level of care. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 4, 2018.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	R-C 12/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

(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 273	Continued From page 13 to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews the facility failed to assure that the healthcare needs of 1 of 5 sampled residents (#3) were met by failing to follow a physician's order to call endocrinology about finger stick blood sugars (FSBS) that were above the ordered perimeters and not making recommended referrals for appointments to cardiology and physical therapy. The findings are: Review of Resident #3's current FL-2 dated 8/31/16 revealed diagnoses included bilateral leg swelling, dyspnea on exertion, and chronic obstructive pulmonary disease. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 9/9/14. a. Review of #3's FL-2 dated 8/31/16 and physicians orders dated 9/6/17 revealed, there was an order for finger stick blood sugar (FSBS) testing before meals and at hour of sleep, call endocrinology for blood sugars readings greater than 350 or less than 70. Review of Resident #3's electronic Medication Administration Record (eMAR) for October 2017 revealed: -On 10/31/17 at 7:30 a.m. FSBS was 3429, and	D 273		

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D 273	Continued From page 14 at 11:30 a.m. the FSBS was 459. -There was no documentation the endocrinologist was contacted on these occasions. Review of Resident #3's eMAR for November 2017 revealed: -On 11/11/17 at 11:30 a.m. FSBS was 377, 11/15/17 at 7:30 a.m. was 543, 11/18/17 at 11:30 a.m. FSBS was 354, 11/24/17 at 11:30 a.m. FSBS was 372, 11/26/17 at 8:00 p.m. FSBS was 399. Review of Resident #3's eMAR for December 2017 revealed: -On 12/2/17 at 8:00 p.m. FSBS was 359, 12/9/17 at 4:30 p.m. FSBS was 374, 12/15/17 at 8:00 p.m. FSBS was 377. Review of Resident #3's record and progress notes kept in the 24 hour book revealed there was no documentation that endocrinology had been notified of FSBS that were greater than 350. Interview with Resident Care Coordinator/Medication Aide (RCC/MA) on 11/20/17 at 11:10 a.m. revealed: -She knew there was an order to notify Resident #3's endocrinologist of FSBS greater than 350 because it was printed on the e-MAR. -She usually would send a fax or call the endocrinologist and write it on a verbal order form if she got a FSBS reading over 350. -She would usually document that she had notified the endocrinologist of FSBS greater than 350 on the resident progress note that is kept in the 24 hour report book. -Sometimes she would get busy and forget to call or forget to document that she had called the endocrinologist. -It was the responsibility of the MA that got the	D 273		

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D 273	Continued From page 15 FSBS reading to notify the endocrinologist of any reading out of the perimeter. Interview with a MA on 12/21/17 at 10:05 a.m. revealed: -She knew Resident #3 had orders to call the endocrinologist for FSBS readings greater than 350 because it was printed on the e-MAR. -It was the responsibility of the MA that got the FSBS reading to notify the endocrinologist of readings out of the perimeter. -She does not remember the last time she had to notify the endocrinologist of Resident #3 having a blood sugar of greater than 350. -She would usually document on the Resident Progress Note that she had notified the endocrinologist if she had to call about FSBS being above the perimeters ordered. -The Resident Progress notes were kept in the 24 Hour Report Book. Attempted telephone call to endocrinology office on 12/21/17 at 9:20 a.m. was unsuccessful. Interview with Resident Care Director (RCD) and Assistant Resident Care Director (ARCD) on 12/21/17 at 11:05 a.m. revealed: -They would expect the MA's to follow written orders about notifying physicians of FSBS greater than 350. -They would expect the MA's to document the notifications. b. Review of Resident #3 primary care provider's office visit progress note dated 11/9/17 revealed, there had been an order written for a referral to cardiology for tachycardia. Review of Resident #3 medical record revealed there was no documentation from a cardiologist.	D 273		

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D 273	Continued From page 16 Interview with Resident #3 on 12/20/17 at 11:00 a.m. revealed Resident #3 did not remember seeing a cardiologist. Refer to interview with Primary Care Provider (PCP) 12/20/17 at 9:10 a.m. Refer to interview with Resident Care Coordinator (RCC) on 12/20/17 at 11:10 a.m. Refer to interview with Corporate Regional Nurse on 12/20/17 at 12:30 p.m. Refer to interview with Residential Care Director (RCD) and ARCD on 12/21/17 at 11:05 a.m. Refer to interview with Administrator on 12/21/17 at 11:30 a.m. c. Review of Resident #3's neurology visit progress note dated 11/16/17 revealed there was a physicians order for physical therapy (PT) for gait instability. Review of Resident #3's medical record revealed there was no documentation written by physical therapy. Interview with Resident # 3 on 12/20/17 at 11:00 a.m. revealed: -Resident #3 did not remember getting any physical therapy. -Resident #3 thought she would benefit from getting Physical Therapy. Refer to interview with Primary Care Provider (PCP) 12/20/17 at 9:10 a.m. Refer to interview with Resident Care Coordinator	D 273		

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D 273	Continued From page 17 (RCC) on 12/20/17 at 11:10 a.m. Refer to interview with Corporate Regional Nurse on 12/20/17 at 12:30 p.m. Refer to interview with Resident Care Director (RCD) on 12/21/17 at 11:05 a.m. Refer to interview with Administrator on 12/21/17 at 11:30 a.m. _____ Telephone interview with the PCP office nurse on 12/20/17 at 9:10 am revealed, the PCP would expect that all recommended referrals would be completed. Interview with RCC on 12/20/17 at 11:10 a.m. revealed: -If there were any recommendations or referrals that were written on a physician's progress notes they were given to the RCD who was in charge of making the appointments. -The paperwork from appointments was put in the box in the RCD and ARCD's office for them to make appointments. -She did not remember seeing a referral for PT or Cardiology for Resident #3. Interview with the facility's Corporate Regional Nurse on 12/20/17 at 12:30 p.m. revealed: -She called PT and Cardiologist offices this morning to see if appointments had been made. -The referral for PT and Cardiology appointments for Resident #3 had not been scheduled. -She had made the appointments 12/20/17 for Resident #3 to have PT and a Cardiology appointments. -She was not sure why the previous RCD had not made the appointments for PT or Cardiology.	D 273		

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D 273	Continued From page 18 -It was the responsibility of the RCD or ARCD to make the referrals and appointments and follow up appointments for the residents at the facility. Interview with RCD and ARCD on 12/21/17 at 11:05 a.m. revealed: -Both the RCD and the ARCD had only worked at the facility for a few weeks. -When the resident returned from an appointment the paperwork was placed into a new order box in the RCD and ARCD office. -The RCD or ARCD was responsible for reviewing progress notes from physician office visits and making any recommended referrals or follow up appointments. -They record the appointment in the Transportation Log. Interview with the Administrator on 12/21/17 at 11:30 a.m. revealed: -He had only been working at the facility for 2 days. -He was not aware of any referrals that were not done. -The RCD and ARCD were responsible for reviewing all the progress notes and making all the appointments for the residents at the facility. -He was not sure why the previous RCD had not made the appointments for Resident #3. -The previous RCD should have made the appointments for Resident #3. -It was the Administrators responsibility to be sure the RCD/ARCD make the residents appointments. The facility failed to assure Resident #3's health care needs were met by not following physicians orders to notify endocrinology about finger stick blood sugars that were outside of perimeters on 8 occasions, and not making referrals to cardiology	D 273		

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D 273	Continued From page 19 and physical therapy. The failure of the facility was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. Review of the facility's Plan of Protection dated 12/21/17 revealed: - Complete audits of resident records, medication administration records, orders, and referrals will be completed by 1/22/18. - Residents needs identified (during the survey) have been resolved. - The Resident Care Director (RCD) /Assistant Resident Care Director (ARCD) and/or designee will follow organizational process for trackining orders, medications, and referrals to ensure completed. - This will be monitored weekly by the RCD/ARCD and/or designee through medication cart audits. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 4, 2018.	D 273		
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.	D 358		

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D 358	Continued From page 20 This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure that 1 of 5 residents sampled (#3) had all her prescribed medications administered as ordered. The findings are: Review of Resident #3's current FL-2 dated 8/31/16 and signed physicians orders dated 9/6/17 revealed: -Diagnoses included bilateral leg swelling, dyspnea on exertion and Chronic Obstructive Pulmonary Disease (COPD). -There was a physicians order for morphine sulfate tablets 15 mg ER (medication for severe pain) take 1 tablet by mouth every 8 hours scheduled to be administered 6:00 a.m., 2:00 p.m. and 10:00 p.m. Review of Resident #3's eMAR revealed: -For 11/20/17-11/30/17 there was an entry for morphine sulfate tablet 15mg ER take 1 tablet every 8 hours scheduled for 6:00 a.m., 2:00 p.m.and 10:00 p.m. all times were documented as not administered. -For 12/1/17-12/19/17 there was an entry for morphine sulfate tablet 15mg ER take 1 tablet every 8 hours scheduled for 6:00 a.m., 2:00 p.m. and 10:00 p.m. all times were documented as not administered. Interview with Resident #3 on 12/19/17 at 4:20pm revealed: -She was aware she had not been receiving her scheduled morphine medication. -She was not sure how long it had been since she had gotten the morphine but she thought it was a few weeks. -When she asked staff about it they had told her it	D 358		

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D 358	Continued From page 21	D 358		

needed to be ordered.
-She was having more back pain since she stopped getting the morphine tablet.
-She would sometimes ask for the as needed pain medication that was ordered.

Interview with RCC/MA on 12/20/17 at 8:45 a.m. revealed:
-Resident #3's prescription for her morphine had no more refills.
-She did not call her Primary Care Provider (PCP) because she gets the morphine prescription from the pain clinic and she did not think the PCP would write a perscription for morphine.
-The facility had made Resident #3 an appointment at the pain clinic she had gone to in the past to get a new prescription for morphine but when she went to the appointment on 11/21/17 the clinic refused to see her because her insurance had changed and they no longer accepted her insurance. She was sent back to the facility without being seen and without a prescription for Morphine.
-The RCC had contacted the Resident #3's family member on 11/21/17 about the pain clinic not seeing the resident due to insurance changes.
-The RCC was told by Resident #3's family member he would look into getting different insurance.
-The RCC does not always document her contacts with doctor's offices or family members.

Telephone interview with the nurse from Resident #3's PCP office on 12/20/17 at 9:10 a.m. revealed:
-The PCP office was not aware that Resident #3 had not been getting her morphine as ordered.
-Resident #3 gets her morphine prescription from the pain clinic.
-If morphine tablets were stopped suddenly it

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D 358	Continued From page 22 could cause symptoms of withdrawal such as nausea or anxiety. Telephone interview on 12/20/17 at 9:35 a.m. with Resident #3's family member revealed: -He would make the appointment for Resident #3 to go to the pain clinic. -He thought there could be serious problems if Resident #3 did not get her morphine. -He felt that Resident #3 was more agitated when he visited her over the last month. Interview with the Resident Care Director (RCD) on 12/21/17 at 11:20 a.m. revealed: -She had been working at the facility for a few weeks. -She did not know Resident #3 was out of her morphine. -She would expect the RCC to let her know if there was a problem getting a prescription for a medication. Interview with Administrator on 12/21/17 at 11:30 a.m. revealed, he would expect the RCD and the ARCD to follow up with primary care providers for a prescriptions needed for residents medications.	D 358		
{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:	{D912}		

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{D912}	Continued From page 23 Based on observations, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to the supervision of residents in the secure unit, and health care. The findings are: 1. Based on observations, record reviews and interviews the facility failed to assure 1 of 5 (#2) sampled residents with a history of falls received proper supervision based on the assessed needs. [Refer to Tag 0270 10A NCAC 13F .0901 (b) Personal Care and Supervision (Type B Violation).] 2. Based on interviews and record reviews the facility failed to assure that the healthcare needs of 1 of 5 sampled residents (#3) were met by failing to follow a physician's order to call endocrinology about finger stick blood sugars (FSBS) that were above the ordered perimeters and not making recommended referrals for appointments to cardiology and physical therapy. [Refer to Tag 0273 10A NCAC 13F .0902 (b) Health Care (Type B Violation).]	{D912}		