STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055011	A. BUILDING: _____ B. WING _____	02/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 Lincoln County Department of Social Services conducted an annual survey on February 20, 2018 and February 21, 2018.	D 000		
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, record reviews and interviews, the facility failed to administer a medication as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #5) who was prescribed Keflex (an antibiotic used to treat bacterial infections). The findings are: Review of Resident #5's current FL2 dated 1/5/18 revealed: -Diagnoses included urinary tract infection (UTI), anxiety, hyperlipidemia and depression. -The medication section of the FL2 documented "see discharge summary". Record review of Resident #5's documentation revealed there was no hospital discharge	D 358		

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summary for 1/5/18.

Interview on 2/20/18 at 3:45pm with the Resident Care Director (RCD) revealed:
-They could not locate Resident #5's discharge summary.
-She would contact the local hospital and obtain another copy of the discharge summary.

Further review of Resident #5's record revealed:
-A resident progress note with a handwritten entry on 1/2/18 at 4:30pm documented Resident #5's power of attorney (POA) had contacted the facility by telephone and reported the resident had a UTI and the hospital was going to keep the resident overnight.
-A resident progress note with a handwritten entry on 1/5/18 at 4:00pm documented Resident #5 was returned to the facility.

Review of Resident #5's hospital discharge summary dated 1/5/18 revealed:
-The discharge summary had been faxed to the facility on 2/20/18 at 4:39pm.
-A primary discharge diagnosis of UTI.
-Resident #5 received Rocephin (an antibiotic used to treat bacterial infections) in the hospital and had been switched to oral Keflex (an antibiotic used to treat bacterial infections) at discharge.
-An order for Keflex 500 mg, one capsule by mouth every 6 hours.

Review of Resident #5's January 2018 Electronic Medication Administration Record (eMAR) revealed there was no entry for Keflex 500 mg, one capsule every 6 hours.

Observation on 2/21/18 at 12:15pm of medications on hand for Resident #5 revealed

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there was no Keflex 500 mg available for administration.

Telephone interview on 2/21/18 at 11:40am with a medication aide (MA) revealed:
-She had documented on a progress note Resident #5's had returned to the facility from the hospital on 1/5/18.
-She could not remember if Resident #5 had returned with any paperwork from the hospital.
-"I don't recall going over any paperwork from the hospital".
-If there had been any paperwork, she would have given it to the Supervisor.

Interview on 2/21/18 at 12:07pm with a second shift Supervisor revealed:
-Residents are discharged from the hospital with "discharge summary paperwork".
-New medication orders were included in the paperwork.
-The facility transportation employee brings the paperwork back to the facility and gives it to the Resident Care Coordinator (RCC).
-Sometimes the residents' family members bring the hospital discharge summary and medication orders to the facility.
-She did not remember seeing the discharge summary or medication orders for Resident #5 upon return to the facility.
-"Normally, I would call the hospital to find out where the paperwork is."
-She had not called the hospital to find out where the paperwork was.

Interview on 2/21/18 at 12:20pm with the Activity Director (AD) revealed:
-She had been the facility transporter until "last week".
-She was responsible for transporting residents

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from the hospital to the facility.
-She would bring the discharge summary and new medication orders from the hospital to the facility.
-The discharge summary and medication orders were given to the RCC.
-She had transported Resident #5 back to the facility from the hospital on 1/5/18.
-The family of Resident #5 had been given the paperwork to bring back to the facility.
-"I told the family to make sure they gave the paperwork to (name of RCC)."

Interview on 2/21/18 at 11:37am with a family member of Resident #5 revealed:
-The resident had been confused and disorientated a few days prior to the hospital admission.
-"She was confused and we recognized the symptoms of a UTI (urinary tract infection); that's why we took her."
-The family member did not remember the discharge summary or medication orders.

Interview on 2/21/18 at 3:30pm with a second family member of Resident #5 revealed:
-She had been at the hospital with Resident #5 during the discharge process.
-She did not remember if the discharge summary or medication orders were given to her.
-She did not know if the discharge summary or medication orders were given to the facility.

Continued interview on 2/21/18 at 10:50am with the RCD revealed:
-The facility transported the resident from the hospital when they are discharged.
-The transportation staff would obtain the discharge paperwork from the hospital.
-The transportation staff would either submit the

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D 358	Continued From page 4 hospital paperwork to the Resident Care office, or, if the RCC or RCD were not available, would submit to the Supervisor. -When the RCC or RCD was not available, the Supervisor would fax the medication orders to the pharmacy. -The Supervisor would place the FL2 and new orders in the new orders mailbox in the Resident Care office. -Either she or the RCC would then review the new orders and confirm it had been faxed to the pharmacy. -She did not know the reason the discharge summary was not in Resident #5's record. -Resident #5 "had not voiced or reported any complaints". -Resident #5 "had not exhibited symptoms of a urinary tract infection". -The facility had contacted Resident #5's primary care physician (PCP) this morning for an order to obtain a urinalysis. Interview on 2/21/18 at 12:25pm with the RCC revealed: -She had contacted the facility's pharmacy around 12:00pm today (2/21/18) and the pharmacy had not received an order for Resident #5's Keflex 500 mg. -She did not know the reason the facility did not have a copy of Resident #5's discharge summary from the hospital. Interview on 2/21/18 at 12:15pm with the facility's Executive Director revealed: -When a resident returned from the hospital, the transportation staff would provide the Supervisor with the hospital paperwork. -She would expect the Supervisor to fax the paperwork to the pharmacy and place the paperwork in the Resident Care mailbox.	D 358		

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D 358	Continued From page 5 -The RCC or RCD would review the paperwork. -She did not know why there was no discharge summary from Resident #5 hospitalization. Interview on 2/21/18 at 12:45pm with Resident #5's PCP revealed: -"The prescriptions should have been brought back to the facility." -Resident #5 may have received enough antibiotics in the hospital to clear the infection. -Resident #5 had chronic UTI's. -Resident #5 was "asymptomatic" (without symptoms of a UTI). -"It's been too long now to know if not receiving the antibiotics was detrimental." -The facility had not scheduled a follow-up appointment with the physician's office. -The facility had called and obtained an order for a urinalysis (a test to detect presence of bacteria) for Resident #5 on 2/21/18.	D 358		