POC was received on 6/19/18 by email and forwarded to Keisha Banks by email on 6/28/18.

PRINTED: 05/29/2018
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080013	A. BUILDING: _____ B. WING _____	05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF SALISBURY	1915 MOORESVILLE ROAD SALISBURY, NC 28147

(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 on 05/01/18 to 05/03/18.	D 000		6-17-18 & on-going
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that 1 of 6 sampled staff (Staff D, Medication Aide)were competency validated for Licensed Health Professional Support (LHPS) tasks of applying and removing thromboembolic decompression (TED) hose. The findings are: Review of Staff D's personnel file revealed: -She had transferred from a sister facility as a Medication Aide (MA) with a hire date at the current facility of 3/26/18. -There was documentation a LHPS competency validation was completed on 12/14/17 at the sister facility. -There was no documentation a LHPS	D 161	D 161 - 10A NCAC 13F .0903 Competency Validation for LHPS Tasks The facility will ensure that all non-licensed personnel and licensed not practicing in the their licensed capacity as governed by their practice act and occupational licensing law are competency validated by return demonstration for any personal care task as required and specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task independently and their ongoing competency is assured through the properly credential staff oversight and supervision. Note: Carillon contends that the facility demonstrated substantial compliance in this rule area. As identified in the statement of deficiencies, the Medication Aide's competency was validated as documented on the LHPS date 12/14/17 while working for Carillon Assisted Living in another facility and prior to transferring.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

CO 6/19/18

Reviewed and Accepted
Keisha Banks 07/02/2018

Division of Health Service Regulation

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D 161	Continued From page 1 competency validation was completed for the current facility. Review of a LHPS competency validation provided by the Executive Director (ED) revealed it was completed on 04/13/18 for the current facility. Review of a resident's Medication Administration Records (MAR) for March, and April 2018 revealed Staff D documented removing TED hose on 03/06/18, 03/07/18, 03/09/18, 03/14/18, 03/15/18, 03/16/28, 03/20/18, 03/21/18, 03/22/18, 03/23/18, 03/28/18, 04/01/18, 04/02/18, 04/03/18, 04/05/18, 04/07/18, 04/09/18, 04/10/18, and 04/12/18. Attempted telephone interview with Staff D on 05/03/18 at 3:00 pm was unsuccessful. Interview with a Resident Care Coordinator (RCC) on 05/03/18 at 11:56 am revealed: -The Registered Nurse (RN) was responsible for ensuring the LHPS competency validation was completed for staff. -The LHPS competency validations were supposed to be completed during orientation to the facility. -New MAs would go to a 3 day class, train with the supervisor, and would have LHPS skills checked off by the nurse. -Staff D transferred to the current facility from a sister facility. -When Staff D transferred to the current facility, her paperwork including documentation of LHPS competency validation, was also transferred to the current facility. -She was not a part of the LHPS process during orientation.	D 161	Validation regarding TED stockings were accomplished as well via Medication Technician training and competency validation. To further ensure compliance, the identified team member was re-validated for skills competency by the Regional Nurse on 5/4/2017. However, in an effort to ensure 100% compliance of this interpretation of this specific rule area and until the state can further clarify this standard of expectation. The facility will ensure all personnel are competency validated by return demonstration for any personal care task including placing or removing TED hose as required upon hire or upon transfer from another Carillon facility although operating under the same credentialing practices and prior to staff performing the personal care task independently. The facility will ensure on-going competency of all staff performing personal care task through proper supervision and oversight.	6-1-18 & on-going

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D 161	Continued From page 2 Interview with the Executive Director (ED) on 05/03/18 at 3:26 pm revealed: -Staff D transferred to the current facility from a sister facility. -Staff transferred from facility to facility within the same network quite often. -The RCC was responsible for ensuring that the LHPS competency validation was completed by the RN. -She did not know a new LHPS competency validation was required for Staff D in the current facility. -She thought Staff D's paperwork, including the LHPS competency validation, could transfer to the current facility. Interview with the regional Registered Nurse (RN) on 05/03/18 at 4:21 pm revealed: -She was filling in as the RN at the facility. -She was responsible for completing the LHPS competency validation for new staff at the facility. -New staff shadowed her or the RCC and completed the LHPS competency validation before they worked independently. -If there were new staff transferring from another facility in the network to the current facility, all records, including the LHPS competency validation, would transfer. -She did not know a LHPS competency validation was needed for Staff D at this facility.	D 161	The Resident Care Director or other Carillon qualified representative will ensure the proper competency validation is completed prior to staff performing any personal care task independently. The Resident Care Director and Executive Director and other personnel will conduct a weekly review and audit of the staff training compliance tracker to ensure compliance of this requirement. The Executive Director, Regional Operations Director, Regional Nurse or other qualified personnel will conduct an additional audit of personnel records monthly to ensure further review and compliance with this requirement.	6-17-18 e-ongoing
D 234	.10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted	D 234	D 234 10A NCAC 13F .0703(a) Tuberculous, Medical Exam & Immunizations Upon admission to the adult care home, each resident will be tested for tuberculous disease in compliance	

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D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted	D 234	D 234 10A NCAC 13F .0703(a) Tuberculous, Medical Exam & Immunizations Upon admission to the adult care home, each resident will be tested for tuberculous disease in compliance	

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D 234	Continued From page 3 by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 5 sampled residents (Resident #4) was tested upon admission for tuberculosis (TB) disease. The findings are: Review of Resident #4's current FL-2 dated 3/21/18 revealed diagnoses included avascular necrosis of the hip, osteoporosis, depression, chronic obstructive pulmonary disease, history of deep vein thrombosis, and chronic pain. Review of Resident #4's Resident Register revealed she was admitted to the facility on 01/28/16. Review of Resident #4's record revealed: -There was a facility generated form for documentation of Tuberculin (TB) skin tests and Pneumonia vaccinations. -There was no documentation of any TB skin tests completed. -Written to the side of the form of where the first and second TB skin tests should have been documented was an unsigned, hand-written note which read, "Chest x-ray done, [family member] was a TB carrier and [Resident #4] has a history of false positive TB tests." -Attached to the form was an x-ray report which indicated that a chest x-ray was performed on	D 234	with the control measure adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. The facility will ensure any resident is tested for tuberculosis disease prior to or upon admission to the facility. The Resident Care Director will verify documentation of the Tuberculosis Test prior to or upon arrival to the facility. If there is no evidence via valid record of current tuberculosis test, The Resident Care Director will complete a tuberculosis test upon arrival to the facility. The Resident Director or other qualified Carillon representative will further verify, for those prospective residents with a documented history of a positive ppd reading, a chest x-ray is obtained specifically ruling out signs and symptoms of active TB and such documentation will be maintained in the residents' records.	6-17-18 & ongoing

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D 234	Continued From page 4 1/12/16 due to a cough. -The x-ray report did not indicate any TB findings. -Hand-written on the bottom right side of the x-ray report, with an illegible signature, was a note dated 1/25/16 which read, "No evidence of TB." -There was no documentation of a TB screening questionaire or any other TB testing in the record. Review of a verbal order form dated 05/02/18 at 1:40 pm revealed: -Resident #4 had reported history of positive purified protein derivative (PPD) reading. -Rule out active TB by x-ray (chest) only. -There were no other orders regarding TB testing or chest xrays to rule out TB. Interview with the Executive Director (ED) on 05/02/18 at 1:45 pm revealed: -She had contacted Resident #4's physician's office and there was no documentation of a positive T skin test at the physician's office. -She had contacted the Rowan County Health Department and they had no documentation of a positive TB skin test. Interview with the ED on 050/3/18 at 3:26 pm revealed: -The Registered Nurse (RN) was responsible for administering TB skin testing. -She had been unable to locate documentation of any positive TB skin tests prior to Resident #4's admission to the facility. -Usually when residents were admitted to the facility, the resident would have a TB skin test prior to being admitted and another TB skin test within 14 days. -It was her understanding Resident #4 was covered for TB skin as long as she had had the chest x-ray prior to admission to the facility.	D 234	The Executive Director and Resident Care Director will conduct an audit of the resident clinical record upon a resident admission verifying the required tuberculosis test has been completed. The Executive Director and Resident Care Director will review the Clinical Compliance tracking to review compliance on a weekly basis. The Executive Director, Regional Operations Director, Regional Nurse or other qualified Carillon representative will conduct monthly audits of resident records to ensure compliance with this requirement.	6-17-18 & On-going

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D 234	Continued From page 5 Interview with the Resident Care Coordinator (RCC) on 05/03/18 at 4:14 pm revealed she was not a part of the TB skin testing process. Interview with the regional Registered Nurse (RN) on 05/03/18 at 4:21 pm revealed: -She would be responsible for TB skin testing of new admissions. -The first TB skin test should be completed prior to residents moving into the facility and a second TB skin test should be completed within 14 days. -She did not know Resident #4 was admitted to the facility with only an x-ray as she was not working at the facility when Resident #4 was admitted. Interview with Resident #4 on 05/03/18 at 4:49 pm revealed: -She did not have a TB skin test prior to being admitted into the facility. -The last time she had a TB skin test was about 10 or more years ago when she was working. -"They said I am a carrier." -She was not sure, but she thought her last TB skin test was negative.	D 234	D 273 10A NCAC 13F .0903(b) Health Care The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. For the specific resident identified, the community followed up with the physician that had placed the medication on hold with no end date, on 5/4/2018. The medication was discontinued and a new medication order was received, filled and is being administered to the resident as prescribed.	6-17-18 & on-going
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 observations, interviews, and record reviews, the facility failed to notify the physician	D 273		

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D 273	Continued From page 6 for 1 of 5 sampled residents (Resident #1) regarding a medication used to treat Parkinson's disease. The findings are: Review of Resident #1's current FL2 dated 07/11/17 revealed: -Diagnoses included dementia with behavioral disturbance. -She was constantly disoriented. -There was an order for Rytary 23.75mg-95mg Extended Release (ER) capsules (used to treat symptoms of Parkinson's disease such as tremors), 1 capsule three times a day at 8:00 am, 1:00 pm, and 6:00 pm. Review of Resident #1's subsequent physician's orders dated 10/19/17 revealed: -A diagnosis of Parkinson's disease. -An order for Rytary 23.75mg-95mg ER capsules, 1 capsule twice a day at 8:00 am and 6:00 pm. Review of Resident #1's medical record revealed a verbal order dated 11/21/17 to hold Rytary 23.75mg-95mg ER capsules until prior authorization was obtained from the provider. Review of Resident #1's November 2017 electronic Medication Administration Record (eMAR) revealed: -An entry for Rytary 23.75mg-95mg ER capsules, take 1 capsule twice a day at 8:00 am and 6:00 pm. - Rytary 23.75mg-95mg ER capsules were documented as administered from 11/01/17 through 11/18/17. - Rytary 23.75mg-95mg ER capsules were documented as not administered at 6:00 pm on 11/18/17, and then not administered at both 8:00	D 273	The facility will ensure all new orders including orders involving a delayed start; hold or time-limited medication orders are verified upon receipt of the order. The Resident Care Director or other qualified Carillon representative will verify the medication including confirmation of the order documented on the resident medication administration record, clarification of any questions regarding the resident order through follow-up with the resident's prescribing physician and a pharmacy representative. The facility in partnership with the assigned pharmacy will conduct a review of the medication order verification process within Carillon and the pharmacy to identify any areas for improvement in the medication verification process.	6-17-18 & On-going

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D 273	Continued From page 7 am and 6:00 pm from 11/19/17 through 11/30/17. - Rytary 23.75mg-95mg ER capsules were marked as discontinued on 11/30/17. Review of Resident #1's December 2017 electronic Medication Administration Record (eMAR) revealed Rytary 23.75mg-95mg ER capsules had been removed from the eMAR. Based on observation and record review, it was determined that Resident #1 was not interviewable. Interview on 05/03/18 at 10:45 am with a first shift Medication Aide (MA) revealed: -She was not familiar with Rytary medication and had never seen it listed on the eMAR. -She had never given Rytary to Resident #1. Telephone interview on 05/03/18 at 12:45 pm with the facility's contracted pharmacy revealed: -The Rytary medication had been placed on hold by the pharmacy in November. -There was a signed verbal order from the provider to hold the medication but not to discontinue it. -The pharmacy discontinued the medication on 11/30/17 because it had been on hold "for an extended amount of time." -There was no documentation of a provider order to discontinue the medication. -The medication required prior authorization as it was not covered by the resident's insurance. -The pharmacy had never received any documentation from the provider or the facility regarding obtaining the prior authorization. -He did not know if the pharmacy had tried to contact the provider or the facility regarding not receiving the prior authorization in November. -The pharmacist was able to fill the prescription	D 273	The Executive Director, Resident Care Director and other qualified Carillon representative will conduct weekly audits of the clinical record including review of any new orders to ensure medication verification and timely follow-up with the resident physician has been completed as required. The Executive Director, Regional Operations Director, Regional Nurse or other qualified Carillon representative will conduct monthly audits of resident clinical records to ensure compliance with this requirement.	6-17-18 & on-going

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D 273	Continued From page 8 as a one-time emergency fill through the insurance company on 05/03/18 but it would require prior authorization for any refills thereafter. -He would inform the facility that the prescription was filled as an emergency fill that day (05/03/18). Telephone interview on 05/03/18 at 2:49 pm with a nurse at Resident #1's primary care provider's (PCP) office revealed: -Resident #1's PCP had not prescribed the Rytary, it had been prescribed by a Parkinson's disease specialist. -Since he did not prescribe the medication, refill requests were not sent to his office. -Since he did not receive any requests for the medication, he did not know that the resident had not been receiving it. -The facility had not contacted his office regarding the medication since November when he gave a verbal order to hold it until insurance approved. -The pharmacy had not contacted his office regarding any prior authorizations for the medication. -The medication was used to treat the symptoms of Parkinson's disease, such as tremors. -Contact information for the Parkinson's disease specialist was not available. Telephone interview on 05/03/18 at 3:00 pm with Resident #1's family member revealed: -She did not know that Resident #1 was not receiving the Rytary medication. -The resident had been prescribed the medication to control progression of her Parkinson's disease. -The facility had not contacted her regarding the need for prior authorization for the medication. -The facility had not informed her that the resident	D 273		6-17-18 on-going

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D 273	Continued From page 9 had not had the medication since November 2017. -The pharmacy had not contacted her regarding needing prior authorization for the medication. -Had she known, she would have paid out of pocket for the medication so that Resident #1 would receive it. Interview on 05/03/18 at 1:00 pm with the Executive Director (ED) revealed: -She had contacted the provider's office and asked for emergency authorization for Rytary. -She was working to have the medication delivered to the facility as soon as possible. -There was no order to discontinue the medication in the resident's record. -The medication was placed on hold in November 2017. -The pharmacy removed the medication from the eMAR at the end of November 2017. -The facility did not know that the pharmacy did not have a discontinue order for the medication when they discontinued it. Telephone interview on 05/04/18 at 1:55 pm with a nurse at Resident #1's primary care provider's office revealed: -The Rytary medication had been changed to another generic version that was covered by insurance on 05/03/18. -The new order had been sent to the facility and pharmacy and the resident had received it on 05/04/18.	D 273		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care	D 287	D287 10A NCAC 13F .0904(b)(2) Nutrition and Food Service The facility will ensure table service will include a napkin and non-disposable place setting consisting	6-17-18

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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
D 287	Continued From page 10 Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a place setting which included a knife, fork, spoon and beverage container for residents who ate in their rooms. The findings are: Observations during the initial tour of the facility on 05/01/18 at 10:55 am revealed: -A resident lying in bed with a plate of food sitting on her stomach from the breakfast meal. -The plate included eggs which she had eaten 90% of, a bowl of oatmeal covered in plastic, and at slice of toast cut into halves wrapped in plastic. -There were two paper cups on her meal tray. -There was no non-disposable or disposable silverware present. Observation of the lunch meal service for residents who were served in their room on 05/01/18 at 12:45 pm revealed: -One resident ate in her room and was served baked ham, roasted potatoes, spinach, a roll, orange juice, and tea. -The orange juice and tea were served in disposable cups with lids. -A plastic spoon was provided with the lunch meal.	D 287	of at least a knife, fork, spoon, plate and beverage containers. The facility will ensure non-disposable silverware, plate and cups I used to serve breakfast, lunch or dinner in the main dining room, as preferred by the resident in their personal rooms or other common space in the community. Immediate in-servicing began on 5/3/2018 for all staff to ensure understanding of state requirements. This will continue ongoing to ensure new hired employees are educated. Disposable dishware and utensils will only be used in such cases as documented request by resident, direction by physician or as warranted for infection control due to illness. The Dining Services Manager, Resident Care Director and Executive Director will ensure all Meals are plated on non-disposable plates, drinks are in non-disposable cups and non-disposable silverware is provided for all meals. All facility staff and management	6-17-18 & on-going

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	HAL080013	A. BUILDING: _____ B. WING _____	05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF SALISBURY	1915 MOORESVILLE ROAD SALISBURY, NC 28147

(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 287	Continued From page 11 Interview with the resident on 05/01/18 at 2:59 pm revealed: -She would prefer to have silverware to use and drink from a cup or glass and not a disposable cup. -She was brought plastic utensils with her meals when she ate in her room. -She had a collection of plastic spoons in her room that were provided with her meals. Observation of the breakfast meal service for residents who were served in their rooms on 05/02/18 between 8:30 and 8:50 am revealed: -There were three residents who ate in their rooms for the breakfast meal. -One resident was served a plate of eggs, toast, and a bowl of cereal. The beverages included coffee and orange juice served in disposable cups with disposable lids; utensils included a non-disposable fork. -A second resident was served a plate of eggs, toast, bacon, and a bowl of grits. The beverages included coffee and orange juice served in disposable cups with disposable lids; utensils included a non-disposable fork. -A third resident was served a plate of eggs and toast. The beverages included hot tea and orange juice served in disposable cups with disposable lids; utensils included a non-disposable fork. Interview with the residents who were served in their rooms for the breakfast meal service on 05/02/18 between 8:30 am and 8:50 am revealed: -"I would rather have silverware." -"I haven't asked for any silverware. I just use what they give me." -"I don't know why they gave me this fork." -"They usually send a plastic spoon and they always send paper cups." -"I prefer something other than paper cups."	D 287	staff will be re-in-serviced on use of non-disposable silverware, cups, bowls and plates for all meals. The Executive Director, Resident Care Director and other qualified Carillon representative will conduct weekly review of meal delivery at different times to ensure compliance with this requirement. The Executive Director, Regional Operations Director, Regional Nurse or other qualified Carillon representative will conduct monthly audits of resident records to ensure compliance with this requirement.	6-17-18 & on-going

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CARILLON ASSISTED LIVING OF SALISBURY	1915 MOORESVILLE ROAD SALISBURY, NC 28147

(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 287	Continued From page 12 -"I keep a plastic knife that I wash and reuse." Observation of the lunch meal service for residents who were served in their room on 05/02/18 between 12:25 pm and 12:45 pm revealed: -There were two residents who ate in their room for the lunch meal. -One resident was served a sandwich, a bowl of tomato soup, and a brownie. The beverages were served in 2 disposable cups with disposable lids; silverware included a non-disposable spoon wrapped in a paper towel. -The second resident was served lasagna, salad, garlic toast, and a brownie. The beverages were served in 2 disposable cups with disposable lids; silverware included a non-disposable fork wrapped in a paper towel. Interview with a personal care aide (PCA) on 05/02/18 at 2:33 pm revealed: -She assisted in the dining hall during the breakfast and lunch meal services. -She sometimes prepared trays for residents who ate in their room. -She picked up a resident's prepared plate from the kitchen and put it on the tray along with a dessert, drinks, and plastic or silverware wrapped in a paper towel. -"Some residents don't want silverware. They want plastic forks, knives, and spoons". -Beverages were put in a paper cup and a plastic lid was placed on the paper cup. -The paper cups and lids were kept behind the serving station in the dining room. Interview with a second PCA on 05/02/18 at 2:40 pm revealed: -She assisted in the dining hall during the breakfast and lunch meal services.	D 287		6-17-18 ongoing

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CARILLON ASSISTED LIVING OF SALISBURY	1915 MOORESVILLE ROAD SALISBURY, NC 28147

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D 287	Continued From page 13 -The PCAs took turns taking trays to residents who ate in their room during each meal. -When she prepared a tray to take to a resident's room, she picked up the prepared plate of food from the kitchen and also included beverages and silverware. -"We normally put regular silverware on the tray, but sometimes there is none washed when we take it to the room. -She knew all residents should receive non-disposable silverware and cups. -She prepared the trays and delivered the meals to the residents who ate in their rooms for the lunch meal service today, 05/02/18. -The resident who was served lasagna was given a non-disposable fork and a knife wrapped in a paper towel and was served beverages in paper cups. -The resident who was served soup and a sandwich was given a non-disposable spoon wrapped in a paper towel and was served beverages in paper cups. Interview with the Dietary Manager (DM) on 02/02/18 at 2:46 pm revealed: -She knew all residents should receive a non-disposable place setting with their meals. -She did not know what silverware and cups the PCAs were putting on the trays for residents who ate in their rooms. -There was silverware and cups in the kitchen that the PCAs were supposed to pick up when they came to the kitchen to pick up the plated food for residents who ate in their rooms. -She did not know PCAs were preparing the trays with paper cups and plastic spoons. -"We don't have any plastic spoons back here." -Paper cups and plastic lids were kept behind the serving station in the dining hall. -"We're going to have a meeting about that one."	D 287		6-17-18 ≤ 6-20-18

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CARILLON ASSISTED LIVING OF SALISBURY	1915 MOORESVILLE ROAD SALISBURY, NC 28147

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D 287	Continued From page 14 Observation of the dining hall and kitchen area on 05/02/18 at 3:12 pm revealed: -There were 42 place settings consisting of non-disposable glasses, coffee cup, knife, spoon, fork, and napkin in the dining hall. -There were 8 non-disposable knives in the silverware cylinder in the kitchen Interview with a second shift PCA on 05/02/18 at 4:20 pm revealed: -She assisted in the dining hall during the dinner meal. -She sometimes prepared trays for residents who ate in their rooms. -When she prepared the tray, she picked up the prepared plate from the kitchen, picked up utensils off of the table or used a plastic spoon from the medication cart, and poured beverages into paper cups and covered with a plastic lid. -"Everyone does that." -She was trained to use either non-disposable silverware from the table or a disposable plastic spoon from the medication cart. -She was told today to use silverware on the trays. -Residents had never asked for non-disposable silverware when they were given plastic spoons. Interview with another second shift PCA on 05/02/18 at 4:27 pm revealed: -She assisted in the dining hall during the dinner meal. -She had been trained by another PCA on how to prepare the trays for residents who ate in their rooms. -Usually when she prepared trays, she picked up a prepared plate from the kitchen, poured beverages in a plastic cup, and grabbed a plastic spoon from the medication cart.	D 287		6-17-18

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF SALISBURY	1916 MOORESVILLE ROAD SALISBURY, NC 28147

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D 287	Continued From page 15 -She did check to see if there was clean silverware in the kitchen before getting a plastic spoon. Interview with the Executive Director (ED) on 05/02/18 at 4:36 pm revealed: -There were about 4 residents who frequently ate in their rooms. -Trays taken to residents' rooms should have had the plate of food, condiments, beverages, a spoon, a knife, and a fork. -She expected for glassware and non-disposable silverware to be on the tray for residents who ate in their room. -The Resident Care Coordinator (RCC) was responsible for training PCAs to assist in the dining hall. -Residents who ate in their rooms should have received the same table service as residents who ate in the dining hall. -"The PCA's were trained incorrectly."	D 287		6-17-18 & on-going
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure an accurate and current listing of residents with physician-ordered therapeutic diets was available for guidance of food service staff for 1 of 6 residents sampled (#2).	D 309	D309 10A NCAC 13F .0904(e)(3) Nutrition and Food Service All diet orders were verified by Regional Nurse and Dietary Tracker updated to ensure accuracy on 5/4/2018. The facility will maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.	

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D 309	Continued From page 16 The findings are: Review of Resident #2's current FL2 dated 01/08/18 revealed: -Diagnoses included dysphagia and dementia. -There was a physician's order for a regular diet with ground meats. Review of the therapeutic diet list posted in the kitchen on 05/01/18 revealed Resident #2 was to receive a regular diet with no indication of ground meats. Review of an updated therapeutic diet list posted in the kitchen on 05/02/218 revealed Resident #2 was listed as being on a regular diet with ground meats. Interview on 05/02/18 at 8:45 am with a first shift personal care aide (PCA) revealed: -Resident #2 had been receiving regular meals. -She did not know Resident #2 had an order for ground meats until a PCA brought Resident #2 ground bacon at the end of the breakfast meal on 05/02/18 and the dietary manager came to the dining room to inform all the staff. Interview with the Executive Director (ED) on 05/03/18 at 9:05 am revealed: -The Resident Care Coordinator (RCC) and the regional Registered Nurse (RN) reviewed the therapeutic diet list weekly. -The diet list was updated when a new resident moved in and when residents had changes in their diet orders. -Resident #2's order for a regular diet with ground meats had been verified by her primary care physician. -She had not known the therapeutic diet list did	D 309	The facility will ensure all new orders including orders involving new diet orders including changes in consistency are verified upon receipt of the order. Upon verification of the new diet order the Resident Care Director, Resident Care Coordinator or other qualified Carillon representative will adjust the Dietary Tracking log listing the resident diet orders and provide to the dietary staff to ensure timely guidance and compliance with the most recent diet order. The Executive Director, Resident Care Director or other qualified Carillon representative will Conduct weekly audits of the resident record to include review of the most recent dietary order and dietary tracker to ensure a current and accurate account of all resident diets. The dietary staff will be in-serviced on the dietary tracker to reiterate awareness and use to ensure proper service delivery and compliance with all diet orders.	6-17-18 & On-going

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D 309	Continued From page 17 not match the physician's order for the therapeutic diet for Resident #2. -Resident #2's diet order had been updated on the therapeutic diet list as a regular diet with ground meats. Interview with the Special Care Unit (SCU) RCC on 05/03/18 at 9:10 am revealed: -The therapeutic diet list was printed every week for staff to check off resident attendance at meals and to make sure that the correct meal was served. -The RCC or the nurse was responsible for making sure that the therapeutic diet list was updated and correct. -The therapeutic diet list was updated when there was a new admission and when there were changes in diet orders. -She reviewed the therapeutic diet list to make sure that residents who were diabetic were listed for aNo Concentrated Sweets (NCS) diet and food allergies were up to date. -If there were changes in a resident's diet order, the dietary manager was notified and a new therapeutic diet list was posted in kitchen for the dietary workers. -She did not know why the therapeutic diet list posted in the kitchen did not match the diet order for Resident #2. Interview with the dietary manager on 05/03/18 at 11:02 am revealed: -The therapeutic diet list for the Assisted Living (AL) residents was posted in the kitchen and the therapeutic diet list for the SCU residents was posted on the SCU food cart for staff guidance. -The RCC was responsible for updating the therapeutic diet list. -She reviewed the therapeutic diet list for both the SCU and AL residents when the list was given to	D 309	The Executive Director, Regional Operations Director, Regional Nurse or other qualified Carillon representative will conduct monthly audits of resident records to ensure compliance with this requirement.	6-17-18 & on-going

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D 309	Continued From page 18 her. -She did not have copies of the diet orders for each resident and only knew what diet each resident was on by reviewing the therapeutic diet list. -She had received an updated therapeutic diet list today (05/03/18) and Resident #2's diet was changed from a regular diet to a regular diet with ground meats on the list. Telephone interview on 05/03/18 at 11:30 am with Resident #2's primary care provider (PCP) revealed Resident #2 had a history of dysphagia which was why she needed ground meats. Based on observations and interviews, it was determined Resident #2 was not interviewable. Telephone interview on 05/03/18 at 12:20 pm with Resident #2's family member revealed Resident #2's diet was changed from a mechanical soft diet to a regular diet with grounds meats when she was admitted to the facility. Interview with the regional RN on 5/3/18 at 4:21 pm revealed: -Her responsibilities included reviewing and updating the therapeutic diet list when a resident had a new diet order or when a new resident moved into the facility. -When she reviewed the therapeutic diet list, she compared it to the diet ordered by the physician in the resident's record. -She reviewed the therapeutic diet list periodically, but did not know how often. -She did not know the therapeuic diet list posted in the kitchen did not match the diet order for Resident #2.	D 309		6-7-18 on-going

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D 310	Continued From page 19	D 310	D310	6-17-18 & on-going
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 residents (#2), with an order for a regular ground meat diet was served as ordered. The findings are: Review of Resident #2's current FL2 dated 01/08/18 revealed: -Diagnoses included dysphagia and dementia. -There was a physician's order for a regular diet with ground meats. Review of the diet list posted in the kitchen dated 05/01/18 revealed Resident #2 was ordered a regular diet with no mention of ground meats. Observation on 05/01/18 from 11:45 am to 1:00 pm of the lunch meal service revealed: -Resident #2's meal consisted of two whole slices of baked ham, large diced roasted potatoes, greens, a dinner roll, a slice of pecan pie, a glass of water, a glass of tea, and a glass of milk. -The ham was not chopped, cut up or ground. -The resident picked up the ham slices with her hands and bit them. -One bite she could not chew, and spit it into her hand and placed it back on the plate.	D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service Immediate re-education for all staff was initiated on 5/4/2018 to ensure understanding of physician prescribed therapeutic diets, where to locate such information and the requirement to serve diets as prescribed. This training will be ongoing for newly hired employees. The facility will ensure all therapeutic diets; including nutritional supplements and thickened liquids will be served as ordered by the resident's physician. The Resident Care Director, Resident Care Coordinator of other qualified Carillon representative will ensure all new diet orders are verified upon receipt including changes in diet or diet orders upon admission of a new resident. The Resident Care Coordinator, Resident Care Director or other qualified Carillon representative will update and verify all new orders are listed on the resident dietary tracker	

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D 310	Continued From page 20 -The resident consumed only 10% of the meal and only 3 bites of ham. Observation on 05/02/18 from 7:50 am to 9:15 am of the breakfast meal service revealed: -Resident #2's meal consisted of scrambled eggs, a bowl of grits, two whole slices of regular bacon, two slices of toast, two glasses of milk, one glass of orange juice, and one glass of water. The bacon was not ground or soft. -The resident consumed 75% of the meal but only 2 bites of the bacon. -The resident demonstrated difficulty chewing the bacon slices as she could not tear it apart with her teeth when she bit into the bacon. -After the second bite of bacon, the resident placed the bacon on the plate and did not attempt to bite it again. -At the end of the meal, a PCA brought a bowl of ground bacon from the kitchen and the resident ate three spoons of ground bacon with grits. Interview on 05/02/18 at 8:45 am with the dietary manager revealed: -She did not know Resident #2 had a diet order for ground meats dated 01/08/18. -She had received the order for regular diet with ground meats that morning (05/02/18) from the Executive Director (ED). -She did not have an order for ground meats for Resident #2 prior to the one the ED had given her that morning -Resident #2 would receive ground meats at each meal starting today (05/02/18). -Resident #2 had been served a regular diet since being admitted to the facility on 01/11/18. Interview on 05/02/18 at 8:45 am with a first shift personal care aide (PCA) revealed: -Resident #2 had been receiving regular meals.	D 310	ensuring the most current and accurate list of resident diets upon receipt of a new diet order. The Resident Care Director, Resident Care Coordinator or other qualified Carillon representative will ensure the updated and current dietary tracker is provided to the dietary staff upon change of any resident diet. The Executive Director, Resident Care Director or other qualified Carillon representative will Conduct weekly audits of the resident record to include review of the most recent dietary order and dietary tracker to ensure a current and accurate account of all resident diets. The Executive Director, Regional Operations Director, Regional Nurse or other qualified Carillon representative will conduct monthly audits of resident records to ensure compliance with this requirement.	6/7/18 & on going

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D 310	Continued From page 21 -She did not know Resident #2 had an order for ground meats until another PCA brought Resident #2 ground bacon at the end of the breakfast meal today (05/02/18) and the dietary manager came to the dining room to inform all the staff. Interview on 05/02/18 at 9:30 am with the Executive Director (ED) revealed: -She did not know Resident #2's FL2 dated 01/08/18 had an order for regular diet with ground meats until 05/01/18. -Once she knew, she had contacted Resident #2's primary care provider the evening of 05/01/18 to get clarification on diet orders. -She decided to ask for clarification since the resident had not been receiving the diet on the FL2. -There were no other diet orders after the FL2 from 01/08/18. -The diet order on the FL2 had somehow been missed at admission for Resident #2. -She had received a diet order clarification from the provider's office that morning (05/02/18), in answer to her request, documenting that Resident #2 was to receive a regular diet with ground meats. -She had informed the dietary manager when the order was received the order was added to the therapeutic diet menu. -Resident #2 would receive ground meats at each meal starting with the lunch meal today 05/02/18. Interview on 05/02/18 at 4:25 pm with a second shift PCA revealed: -She had just found out that afternoon Resident #2 was supposed to receive a regular diet with ground meats. -Resident #2 had been on a regular diet previously.	D 310		6/1/18 & On-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080013	A. BUILDING: _____ B. WING _____	05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF SALISBURY	1915 MOORESVILLE ROAD SALISBURY, NC 28147

(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 310	Continued From page 22 Telephone interview on 05/03/18 at 11:30 am with Resident #2's primary care provider (PCP) revealed: -He had written an order for a regular diet with ground meats on 05/02/18 after he received a request for clarification from the facility. -Resident #2 had a history of dysphagia which was why she needed ground meats. -He had not written Resident #2's FL2 dated 01/08/18, it was completed by a provider at the resident's prior facility. -The resident had been on a mechanical soft diet at her previous facility, but that was not offered at the current facility. -He had not received any reports from staff or the resident's family with any concerns the resident had difficulty with the regular diet. -He had seen the resident twice, once in January and once in March. -He did not feel that the resident had any negative outcomes from not receiving ground meats prior to the order clarification on 05/02/18. Telephone interview on 05/03/18 at 12:20 pm with Resident #2's family member revealed: -Resident #2 had moved to the facility from another facility on 01/11/18. -Resident #2 had been on a mechanical soft diet at the previous facility due to difficulty chewing and swallowing. -The current facility did not offer a mechanical soft diet so Resident #2's diet had been changed to a regular diet with ground meats. -He usually came to visit at dinner and had been requesting sandwiches for Resident #2 because "she was able to eat them better than the regular meals." -He did not know Resident #2 was not receiving the correct diet as he did not observe these meals.	D 310		6/7/18 & on-going

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CARILLON ASSISTED LIVING OF SALISBURY	1915 MOORESVILLE ROAD SALISBURY, NC 28147

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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 reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 1 of 5 sampled residents (Resident #5) regarding an order for sliding scale insulin (SSI) with no parameters for SSI provided. The findings are: Review of Resident #5's current FL2 dated 05/14/17 revealed diagnoses included hypertension, atrial fibrillation, and diabetes mellitus type 2. Review of a subsequent physician's order dated 05/30/17 revealed an order to check finger stick blood sugar (FSBS) 2 times a day. Review of Resident #5's record revealed	D 344	D344 10A NCAC 13F .1002(a) Medication Orders. On 5/4/2018, The Regional Nurse received a clarification order for the resident identified. Community implemented order as written and in-serviced Med Techs on clarified order. All orders pending clarification will be reviewed daily by RCD, RCC and/or ED to ensure proper clarification is completed. The facility will ensure all new orders including orders received upon admission or readmission are verified upon receipt of the order. The Resident Care Director or other qualified Carillon representative will verify the medication including confirmation of the order documented on the resident medication administration record, clarification of any questions regarding the resident order through follow-up with the resident's prescribing physician and a pharmacy	6-17-18 F On-going

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF SALISBURY	1915 MOORESVILLE ROAD SALISBURY, NC 28147

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D 344	Continued From page 24 subsequent signed physician's orders dated 10/30/17 to check FSBS 2 times a day and administer 25 units of Lantus insulin every morning. Review of Resident #5's subsequent physician's orders revealed orders for Lantus insulin as follows: -On 11/08/17, increase Lantus insulin to 31 units daily. -On 12/21/17, increase Lantus insulin to 38 units daily. -On 01/04/18, increase Lantus insulin to 44 units daily. -On 02/22/18, increase Lantus insulin to 60 units daily. -On 03/28/18, increase Lantus insulin to 70 units daily. Review of a subsequent physician's order dated 2/22/18 revealed: -An order for Novolog insulin (a rapid acting injectable medication used to lower blood sugar) per sliding scale 3 times daily, prior to meals as instructed. -There was no assigned amount of Novolog insulin to administer for the sliding scale insulin (SSI) ordered with FSBS. Review of Resident #5's February 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check and record blood sugar before breakfast and dinner at 7:30 am and 4:30 pm. -The resident's blood sugar ranged from 126 to 385. -There was an entry in the "prn (as needed)" section of the eMAR for Novolog insulin inject 3 times a day before meal(s) as directed, per SSI,	D 344	representative. The Resident Care Director, Resident Care Coordinator or other qualified Carillon representative will ensure any clarification of medications orders are documented accordingly in the resident's clinical record. The Executive Director, Resident Care Director and other qualified Carillon representative will conduct weekly audits of the clinical record including review of any new orders to ensure medication verification and timely follow-up with the resident physician has been completed as required. The Executive Director, Regional Operations Director, Regional Nurse or other qualified Carillon representative will conduct monthly audits of resident clinical records to ensure compliance with this requirement.	6-17-18 & on-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF SALISBURY	1915 MOORESVILLE ROAD SALISBURY, NC 28147

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D 344	Continued From page 25 as needed beginning 02/12/18 with no scheduled time for administration and no parameters. Review of the March 2018 eMAR for Resident #5 revealed: -There was an entry for check and record blood sugar before breakfast and dinner at 7:30 am and 4:30 pm. -The resident's blood sugar ranged from 141 to 429. (Resident #5's primary care physician was contacted for elevated blood sugar). -There was an entry in the "prn (as needed)" section of the eMAR for Novolog insulin inject 3 times a day before meal(s) as directed, per SSI, as needed beginning 02/12/18 with no scheduled time for administration and no parameters. Review of the April 2018 eMAR for Resident #5 revealed: -There was an entry to check and record blood sugar before breakfast and dinner at 7:30 am and 4:30 pm. -The resident's blood sugar ranged from 90 to 366. -There was an entry in the "prn (as needed)" section of the eMAR for Novolog insulin inject 3 times a day before meal(s) as directed, per SSI, as needed beginning 02/12/18 with no scheduled time for administration and no parameters. Review of Resident #5's progress notes revealed there was no documentation of the prescribing physician (Resident #5's Endocrinologist) being contacted to request clarification of orders for SSI (parameters for administering Novolog insulin as SSI). Interview on 05/021/18 at 10:30 am with Resident #5 revealed: -She knew she received insulin one time a day for	D 344		6-17-18

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D 344	Continued From page 26 her diabetes. -She had not experienced any problems with her medications, including insulin, being available and administered. Telephone interview on 05/02/18 at 11:15 am with the contracted pharmacist revealed: -The pharmacy received the physician's order dated 02/22/18 for Resident #5's Novolog insulin per sliding scale 3 times daily, prior to meals as instructed. -The pharmacy had documentation stating the prn (as needed) was for when the physician was notified for elevated blood sugar and ordered a one time dose of Novolog insulin to lower the blood sugar. -The pharmacist was unable to identify if the note was added per conversation with the facility or the prescriber. -The pharmacy discontinued Novolog SSI on 04/24/18 according to the pharmacist, however, the notes in the pharmacy computer were not clear as to who discontinued the medication or why. Telephone interview on 05/02/18 at 11:35 am with a nurse at Resident #5's Endocrinology office revealed: -Resident #5's Novolog insulin was ordered on 02/22/18 when the resident was seen in the office. -The parameters for administering sliding scale insulin varied from one resident to the next. -The parameters for Resident #5's SSI Novolog should have accompanied the order for SSI on 02/22/18. -She was unable to locate documentation for Resident #5's Novolog sliding scale parameters in the resident's record at the clinic. -There was no documentation for the facility	D 344	6-17-18 & on-going	

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CARILLON ASSISTED LIVING OF SALISBURY	1916 MOORESVILLE ROAD SALISBURY, NC 28147

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D 344	Continued From page 27 contacting the physician's office for clarification of the SSI parameters. -There were no notes the prescriber had discontinued the Novolog insulin administered by sliding scale. -The nurse would have to check with the physician to see why the Novolog SSI parameters were not documented in the resident's office notes or if any special information was available regarding the resident's insulin. Interview on 05/02/18 at 12:50 pm with the special care unit Resident Care Coordinator (RCC) revealed: -She was the RCC at the time Resident #5 received the order for Novolog insulin from her physician. -The facility policy was to notify a resident's physician when a resident had a blood sugar value greater than 350. -Resident #5 did not have an order for Novolog insulin prior to 02/22/18 that would cover the one time Novolog insulin doses that were being authorized by the after-hours physicians when called by the facility for blood sugars greater than 350. -Resident #5's family member brought the order to the facility after a physician's visit to the Endocrinologist on 02/22/18. -Her understanding was that the SSI Novolog order was for the "prn" Novolog for the facility to be able to obtain the insulin from the pharmacy. Interview on 05/02/18 at 1:30 pm with the regional Registered Nurse (RN) revealed: -She had been coming to the facility monthly to conduct routine audits of residents' records. -She did not know Resident #5 had an order for Novolog SSI.	D 344		6-17-18 & ongoing

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D 344	Continued From page 28 -Facilities owned by the corporation did not admit residents with SSI and prescibers should be contacted to discontinue SSI orders. -She could not find any documentation for clarification of Resident #5's SSI order with the Endocrinology clinic or the resident's primary care physician (PCP) -She would Immediately contact Resident #5's PCP and Endocrinologist for discontinuation of the SSI Novolog. Telephone interview on 05/03/18 at 10:50 am with a representative at Resident #5's Endocrinology office revealed: -The facility should be contacting the Endocrinology office for orders regarding Resident #5's blood sugar. -The Endocrinology office had an on-call staff person available at all times, if needed. -There was no additional information available regarding Resident #5's SSI parameters. -The facility should be administering SSI to Resident #5 and should have called to clarify the parameters when the orer was received. -There was no information for discontinuing SSI on 04/24/18. Telephone interview on 05/03/18 at 11:30 am with Resident #5's Power of Attorney (POA) revealed: -She saw the resident several times each week. -She took the resident to her physician appointments, both PCP and the Endocrinologist. -She knew the facility did not accept residents with sliding scale insulin. -She had spoken with the Endocrinologist during the visit in February 18 regarding needing a prescription for Novolog for the facility to have a supply on hand when blood sugar values were greater than 350 and the physician was contacted.	D 344		6-17-18 & on-going

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D 344	Continued From page 29 -It was her understanding that the Endocrinologist knew the facility did not administer routine sliding scale insulin and was only receiving stat doses of SSI Novolog occasionally for FSBS over 350. Interview on 05/03/18 at 4:20 pm with the Executive Director (ED) revealed: -She did not know Resident #5 had an order for Novolog SSI dated 02/22/18 that needed to be clarified for use only when blood sugars were greater than 350 and the on-call prescribers were contacted per facility policy. -The assisted living RCC was responsible to assure all medication orders were clear before appearing on the eMAR. -The ED would work with the regional RN to assure Resident #5's Novolog insulin order was clarified.	D 344		6-17-18 & on-going
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety;	D 482	D482 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives The facility has not and will not use physical restraint or any alternative equipment for physical restraint under any circumstances. On 5/4/2018 all residents with bed rails were evaluated for ability to safely reposition using bed rails. Physician orders for residents with continued need for bed rails are located in respective resident files, nursing evaluation is noted in resident's record and PT evaluation orders have been requested as additional oversight. All	

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D 482	Continued From page 30 (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: TYPE B VIOLATION. Based on observations, interviews, and record reviews, the facility failed to assure physical restraints were used only after an assessment and care planning process had been completed through a team process and used only with a written order from a physician for 3 of 3 sampled	D 482	staff in-servicing regarding restraints versus assistive/ repositioning devices was initiated on 5/4/2018 and is ongoing. Responsible parties have been notified and are documented consent for use of bed rails. Any new orders for bed rails will require MD order, PT evaluation and documented family consent. The facility will ensure that any physical or mechanical equipment utilized to assist a resident for positioning or mobility purposes, efforts to help resident reduce decline in functioning and improve opportunity for the residence's independence are only utilized under the following circumstances 1) the resident has a medical condition or symptoms that warrant the use of physical or mechanical equipment and would absolutely never be utilized as a restraint or for punitive purposes 2) used only in accordance with a physicians order 3) provides the least restrictive alternative possible which supports a residents need	6-17-18 & on-going

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D 482	Continued From page 31 residents (#1, #6, and #7) residing In the Special Care Unit (SCU) who had full bilateral bed rails (#7), ½ rails (#1), and ¼ rails (#6). The findings are: 1. Review of Resident #7's current FL2 dated 03/01/18 revealed: -Diagnoses included dementia. -She was intermittently disoriented. -The section for restraints was blank. -The recommended level of care was secured unit. -There was an order for hipsters at all times for protection due to falls. -There was an order for a pull alarm at all times when in bed or chair. Review of Resident #7's record revealed the resident was admitted to the facility 02/23/2015. Observation of Resident #7's room on 05/03/18 at 8:30 am revealed: -The resident was lying in her bed. -The resident's bed was located toward the window and had bilateral full length rails. -Both bed rails were in the up position. Observation of Resident #7's room on 05/03/18 at 12:30 pm revealed: -The resident was not in the room. -The bed rail next to the window was in an up position. -The bed rail on the other side of the bed was In the down position. Review of a Resident #7's record revealed: -There was a physician's order dated 04/20/18 for "hospital bed with ¼ rails for repositioning" and scoop (concave) mattress.	D 482	4) used in to prevent potential decline in the residents conditioning and allow support in maintenance of the residents independence 5) used only after an assessment and care planning has been completed 6) the supportive equipment is used according to manufacturer's instruction and compliance with physician's orders 7)Used in conjunction with alternatives which provide support in the resident's ability, independence, mobility or positioning and do not include restraint of any kind. The Resident Care Director, Executive Director or other qualified Carillon representative will verify any order for adaptive, physical or mechanical equipment to include such supports as bed rails upon receipt of the order. The Resident Care Director, Resident Care Coordinator, Executive Director will physically inspect all equipment upon implementation to ensure there is no component of restraint.	6-17-18 & On-going

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D 482	Continued From page 32 -There was no physician's order for full length bed rails available for review. -There was no physical restraint consent form or documentation for alternative to restraint assessment available for review. Review of Resident #7's current assessment and resident care plan signed and dated 09/01/17 revealed: -The resident was alert, verbal, and oriented to self. -The resident required extensive assistance with transferring, and ambulation/locomotion. -The resident was totally dependent with assistance for bathing, toileting, dressing and grooming. -The resident had no physical restraint documented on the care plan. Review of Resident #7's Licensed Health Professional Support (LHPS) review dated 02/07/18 revealed: -The marked LHPS tasks were ambulation with assistive device (wheelchair), inhalation of medications by nebulizer, application and removal of glasses, and transferring semi or non-ambulatory residents. -The resident was noted to be alert to self and general surroundings, and mobile via wheelchair with staff assist. -The resident was seen by Hospice. -No recent falls were noted this quarter. -Hipsters were to be in place at all times and pull alarm in place at all times. -There was no documentation for bed rails. Telephone interview on 05/03/18 at 12:40 pm with Resident #7's Power of Attorney (POA) revealed: -Resident #7 resided at the facility for 3 years. -Resident #7 had the hospital bed with full bed	D 482	The Executive Director, Resident Care Director or other qualified Carillon representative will conduct an monthly audit of all mechanical or adaptive equipment ordered in support of the residents' needs to ensure continued and on-going compliance. An evaluation of a resident's condition and need for mechanical or adaptive equipment will be completed on a quarterly basis to ensure continuity of care and proper adjustments to the resident's service plan are implemented accordingly. The Executive Director, Regional Operations Director, Regional Nurse or other qualified Carillon representative will conduct monthly audits of resident clinical records to ensure compliance with this requirement.	6-17-18 & On-going

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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
D 482	Continued From page 33 rails since she came to the facility. -The POA had also purchased a scoop mattress to help prevent falls shortly after arriving at the facility (Observation on 05/03/18 revealed a scoop shaped mattress on Resident #7's bed). -"Resident #7's last fall from the bed was 09/06/16; the bed rails help keep her from falling out of bed." -She did not remember signing a consent for bed rails but she would sign forms if the facility requested; she wanted rails or anything that would protect the resident from falling. -She had hospice services for a long time, but may not now. -Resident #7 was getting a new bed soon, according to the facility, since the resident was no longer had Hospice services. Interview on 05/03/18 at 3:35 pm with two personal care aides (PCA) in the special care unit revealed: -The PCAs were trained by a former Resident Care Coordinator and former PCAs. -They put the bed rails up for Resident #7 whenever she was in the bed to help prevent her from falling out of the bed. -Neither PCA knew when the last time Resident #7 had fallen out of bed. Interview on 05/03/18 at 3:40 pm with a third PCA revealed: -She was trained by PCAs to put the bed rails up on Resident #7 whenever she was in the bed. -She had worked at the facility for longer than Resident #7 had been at the facility and had always raised her rail up when she was in the bed. Interview on 05/03/18 at 4:00 pm with a regional operations director revealed:	D 482		6-17-18 & on-going

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D 482	Continued From page 34 -He came to the facility, along with other regional representatives to perform random corporate audits and reviews. -The facility was part of the corporation and was supposed to be restraint free. -Resident #7 had a new bed ordered on 04/20/18 and the order included ¼ rails for repositioning. The bed was ordered and delivered today. -Resident #7 must have had full bed rails on the bed ordered by Hospice and they were overlooked. Refer to interview on 05/03/18 at 3:00 pm with the regional Registered Nurse (RN). Refer to interview on 05/03/18 at 4:00 pm with the Executive Director. 2. Review of Resident #6's current FL2 dated 11/14/17 revealed: -Diagnoses included unspecified dementia Alzheimer's. -She was constantly disoriented. -The section for restraints was blank. -The recommended level of care was secured unit. -There was an order for hipsters at all times. -There was an order for a bed pull alarm at bedtime. Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 10/10/2013. Observation of Resident #6's room on 05/03/18 at 3:35 pm revealed: -The resident was dressed and lying on her bed in the room. -The resident's bed was located toward the side wall and had bilateral ¼ rails.	D 482		6-17-18 & on-going

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D 482	Continued From page 35 -The bed rail next to the wall and on the other side of the bed were in the up position. Review of a Resident #6's record revealed: -There was no physician's order for ¼ length bed rails available for review. -There was no physical restraint consent form or documentation for alternative to restraint assessment. Review of Resident #6's care plan signed and dated 03/07/18 revealed: -The resident was oriented to self. -The resident required limited assistance with transferring. -The resident required extensive assistance with ambulation/locomotion, and grooming. -The resident was totally dependent with assistance for bathing, toileting, and dressing. -The resident had hipsters and chair alarm documented. -The resident had no physical restraint documented on the care plan. Review of Resident #6's Licensed Health Professional Support (LHPS) review dated 03/14/18 revealed: -The marked LHPS tasks were ambulation with assistive device (wheelchair and walker), application and removal of glasses, physical therapy, and transferring semi or non-ambulatory residents. -The resident was noted to be alert to self only, and ambulates via wheelchair. -A fall on 1/11/18 was noted this quarter. -There was no documentation for bed rails. Telephone interview on 05/03/18 at 12:40 pm with Resident #6's Power of Attorney (POA) revealed: -Resident #6 had been a resident at the facility for	D 482		6-17-18 & On-going

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D 482	Continued From page 36 many years (since 2013). -Resident #6 has had the bed rails "for a few years". -Originally, the bed rails help to keep her from falling out of bed. -The resident could stand and pivot from wheel chair to bed and would need the rail for assistance. -She did not remember signing a consent for bed rails but she would sign forms if the facility requested. Interview on 05/03/18 at 3:35 pm with two personal care aides (PCA) in the SCU revealed: -The PCAs were trained by a former Resident Care Coordinator (RCC) and former PCAs. -They put the bed rails up for Resident #6 whenever she was in the bed to help prevent her from falling out of the bed. -Neither PCA knew when was the last time Resident #6 had fallen out of bed. Telephone interview on 05/04/18 at 1:15 pm with Resident #6's physician's office nurse revealed there was no documentation for the facility contacting the physician's office for an order for bed rails for Resident #1, or any documentation of an assessment for bed rails for the resident. Interview on 05/03/18 at 3:40 pm with a third PCA revealed she was trained by a former RCC and former PCAs to put the bed rails up on Resident #6 whenever she was in the bed. Refer to interview on 05/03/18 at 3:00 pm with the regional Registered Nurse (RN). Refer to interview on 05/03/18 at 4:00 pm with the Executive Director.	D 482		6-14-18 & on-going

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D 482	Continued From page 37 3. Review of Resident #1's current FL2 dated 07/11/17 revealed: -Diagnoses included dementia with behavioral disturbance. -She was constantly disoriented. -The section for restraints was blank. -The recommended level of care was secured unit. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 07/27/16. Observation of Resident #1's room on 05/01/18 at 10:32 am revealed: -The resident was not in the room. -The resident's bed was pushed against the wall and had bilateral 1/4 rails. -The bed rail next to the wall was in an up position. -The bed rail on the other side of the bed was in the down position. Observation of Resident #1's room on 05/03/18 at 8:30 am revealed: -The bed rail next to the wall was in an up position. -The bed rail on the other side of the bed was in the up position. Review of a Resident #1's record revealed: -There was a physician's order dated 07/26/16 for a concave mattress, semi-electric bed, and wheelchair. -There was no physician's order for bed rails available for review. -There was no physical restraint consent form or documentation for alternative to restraint assessment.	D 482		6-17-18

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D 482	Continued From page 38 Review of Resident #1's assessment and care plan signed and dated 09/01/17 revealed: -The resident was alert, verbal, and oriented to person and family members. -The resident required extensive assistance with each task of bathing, toileting, transferring and ambulation/locomotion. -The resident required limited assistance with grooming. -The resident had no physical restraint documented on the care plan. Review of Resident #1's Licensed Health Professional Support (LHPS) review dated 03/14/18 revealed: -The marked LHPS tasks were ambulation with assistive device (wheel chair), and transferring semi or non-ambulatory residents. -The resident was noted to be alert and oriented to general surroundings, and mobile via wheelchair with staff assist to propel. -There was documentation a pillow was used on the resident's left side to keep the resident upright. -No recent falls were noted this quarter. -There was no documentation for bed rails. Telephone interview on 05/03/18 at 3:08 pm with Resident #1's Power of Attorney (POA) revealed; -Resident #1 came to the facility with an order for a hospital bed, a special mattress, and her wheelchair. -The bed rails were to help keep Resident #1 from falling out of the bed. -She did not recall signing a consent for bed rails but she would sign forms if the facility requested. -She thought she remembered giving verbal consent for Resident #1 to have ralls on her bed. Interview on 05/03/18 at 3:35 pm with two	D 482		6-17-18 & on-going

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D 482	Continued From page 39 personal care aides (PCA) in the SCU revealed: -The PCAs were trained by a former Resident Care Coordinator and former PCAs. -They put the bed rail up for Resident #1 whenever she was in the bed to help prevent her from falling out of the bed. -Neither PCA knew the last time Resident #1 had fallen out of bed. Interview on 05/03/18 at 3:40 pm with a third PCA revealed: -She was trained by a former RCC and former PCAs. -She had worked at the facility for longer than Resident #1 had been at the facility and had always raised her bed rail up when she was in the bed. Telephone interview on 05/04/18 at 1:15 pm with Resident #1's physician's office nurse revealed there was no documentation for the facility contacting the physician's office for an order for bed rails for Resident #1, or any documentation of an assessment for bed rails for the resident. Refer to interview on 05/03/18 at 3:00 pm with the regional Registered Nurse (RN). Refer to interview on 05/03/18 at 4:00 pm with the Executive Director Interview on 05/03/18 at 3:00 pm with the regional Registered Nurse (RN) revealed: -The regional RN had not addressed bed rails at the facility previously. -All corporate facilities, including this facility, were supposed to be restraint free. -Usually, the facility would have physical therapy involved in the decision for a resident to have a bed rail.	D 482		6-17-18 & on-going

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D 482	Continued From page 40 -The facility should get an order for a bed rail, and consent, if it was put in place because of a fall prevention. -Any resident with bed rails should have originally had an order for ¼ to ½ rails for mobility only. -The residents' records had been thinned and orders for bed rails for most of the residents were not available for review. -She would ensure the primary care physician for all residents with a side rail was contacted for the need for the rail were assessed, an order for bed rails obtained, consent forms signed, and documentation was available for review. Interview on 05/03/18 at 4:00 pm with the Executive Director revealed: -The facility was supposed to be restraint free. -She did not consider short rails (1/4) to be a restraint. -The residents should have a physician's order for bed rails to be used for mobility where present. -The orders for bed rails may have been thinned from the residents' records, but the orders could not be located for review. -She would make sure all residents with side rails were reviewed for appropriateness of the rail and all paperwork (order, consent, and assessments) was completed or the rail would be removed. The facility failed to assure physical restraints were used only after an assessment and care planning process had been completed through a team process and used only with a written order from a physician for 3 of 3 sampled residents (#1, #6, and #7) who had full bilateral bed rails (#7), ½ rails (#1), and ¼ rails (#6) which was detrimental to the health, safety and welfare of the residents and constitutes a Type B. Violation.	D 482		6-17-18 & on-going

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D 482	Continued From page 41 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 17, 2018.	D 482	D914 G.S. 131D-214-21(4) Declaration of Resident Rights The Facility has and will always ensure all residents are free from mental and physical abuse, neglect and exploitation. The facility has not and will not use physical restraint or any alternative equipment for physical restraint under any circumstances. The facility will ensure that any physical or mechanical equipment utilized to assist a resident for positioning or mobility purposes, efforts to help resident reduce decline in functioning and improve opportunity for the residence's independence are only utilized under the following circumstances 1)the resident has a medical condition or symptoms that warrant the use of physical or mechanical equipment and would absolutely never be utilized as a restraint or for punitive purposes 2)used only in accordance with a physicians order 3)provides the least restrictive alternative possible which supports a residents need 4)used in to prevent potential decline in the residents conditioning and allow support in maintenance of the residents independence 5)used only after an assessment and care planning has been completed 6) the supportive equipment is used according to manufacturer's instruction and compliance with physician's orders	6-17-18
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free of neglect and exploitation as related to the use of physical restraints and alternatives. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure physical restraints were used only after an assessment and care planning process had been completed through a team process and used only with a written order from a physician for 3 of 3 sampled residents (#1, #6, and #7) residing in the Special Care Unit (SCU) who had full bilateral bed rails (#7), ½ rails (#1), and ¼ rails (#6). [Refer to Tag D 0482, 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives (Type B Violation).]	D914		
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. (b) Beginning October 1, 2013, an adult care	D935		

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D935	Continued From page 42 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. This Rule is not met as evidenced by:	D935	(Continunation)D914 G.S. 131D-214-21(4) Declaration of Resident Rights 7)Used in conjunction with alternatives which provide support in the resident's ability, independence, mobility or positioning and do not include restraint of any kind. The Resident Care Director, Executive Director or other qualified Carillon representative will verify any order for adaptive, physical or mechanical equipment to include such supports as bed rails upon receipt of the order. The Resident Care Director, Executive Director or other qualified Carillon representative will verify any order for adaptive, physical or mechanical equipment to include such supports as bed rails upon receipt of the order. The Resident Care Director, Resident Care Coordinator, Executive Director will physically inspect all equipment upon implementation to ensure there is no component of restraint. The Executive Director, Resident Care Director or other qualified Carillon representative will conduct an monthly audit of all mechanical or adaptive equipment ordered in support of the residents need to ensure continued and on-going compliance. An evaluation of a resident's condition and need for mechanical or adaptive equipment will be completed on a quarterly basis to ensure continuity of care and proper adjustments to the resident's service plan are implemented accordingly. The Executive Director, Regional Operations Director, Regional Nurse or other qualified Carillon representative will conduct monthly audits of resident clinical records to ensure compliance with this requirement.	6-17-18 & on-going

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D935	Continued From page 43 Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 sampled medication aides (Staff D) who administered medications had a Medication Clinical Skills Competency checklist completed prior to administering medications. The findings are: Review of Staff D's personnel file revealed: -She had transferred from a sister facility to the current facility as a medication aide (MA) with a hire date at the current facility of 03/26/18. -There was documentation a Medication Clinical Skills Checklist was completed on 12/14/17 at the sister facility. -There was no documentation a Medication Clinical Skills Checklist was completed for the current facility. Review of a Medication Clinical Skills Checklist provided by the Executive Director (ED) revealed it was completed on 04/13/18 for the current facility. Review of Resident #4's Medication Administration Records (MAR) for February, March, and April 2018 revealed Staff D documented administration of medication on 02/27/18, 02/28/18, 03/06/18, 03/07/18, 03/09/18, 03/14/18, 03/15/18, 03/16/18, 03/20/18, 03/21/18, 03/22/18, 03/23/18, 03/26/18, 03/28/18, 04/01/18, 04/02/18, 04/03/18, 04/05/18, 04/07/18, 04/09/18, 04/10/18, 04/11/18, and 04/12/18. Attempted telephone interview with Staff D, MA, on 05/03/18 at 3:00 pm was unsuccessful. Interview with a Resident Care Coordinator (RCC) on 05/03/18 at 11:58 am revealed:	D935	D935 G.S. 131D-4.5B(b) Medication Aides; Training and Competency Note: Carillon contends that the facility demonstrated substantial compliance in this rule area. As identified in the statement of deficiencies, the Medication Aide's competency was validated as documented on the LHPS date 12/14/17 while working for Carillon Assisted Living in another facility and further validated on 4/13/2018. To further ensure compliance, the identified team member was re-validated for skills competency by the Regional Nurse on 5/4/2017. The facility will ensure all Medication Technicians administering medications will have a Medication Skills Competency checklist is completed prior to the administration of medications. The Resident Care Director and Executive Director or other personnel will conduct a weekly review and audit of the staff training compliance tracker to ensure compliance of this requirement. The Executive Director, Regional Operations Director, Regional Nurse or other qualified personnel will conduct an additional audit of personnel records monthly to ensure further review and compliance with this requirement.	6-17-18 & on-going

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D935	Continued From page 44 -The Registered Nurse (RN) was responsible for ensuring the Medication Clinical Skills Checklist was completed for MAs. -The Medication Clinical Skills Checklist was supposed to be completed with orientation to the facility. -New medication aides (MA) would go to a 3 day class, train with the supervisor in charge, and would have their Medication Clinical Skills Checklist checked off by the nurse. -Staff D transferred to the current facility from a sister facility. -When Staff D transferred to the current facility, her paperwork including documentation of Medication Clinical Skills Checklist, was also transferred to the current facility. -She was not involved in the process of completing the Medication Clinical Skills Checklist. Interview with the Executive Director (ED) on 05/03/18 at 3:26 pm revealed: -Staff D transferred to the current facility from a sister facility. -Staff transferred from facility to facility within the same network quite often. -The RCC was responsible for ensuring the Medication Clinical Skills Checklist was completed by the RN. -She did not know the Medication Clinical Skills Checklist was required for Staff D at the current facility. -She thought Staff D's paperwork, including the Medication Clinical Skills Checklist could transfer to the current facility. Interview with the regional RN pm 05/03/18 at 4:21 pm revealed: -She was responsible for completing the Medication Clinical Skills Checklist for new staff	D935		6-17-18 & on-going

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CARILLON ASSISTED LIVING OF SALISBURY	1915 MOORESVILLE ROAD SALISBURY, NC 28147

(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 45 at the facility. -New staff shadowed her or the RCC and completed the Medication Clinical Skills Checklist after they administered medication to residents. -If there were new staff transferring from a sister facility to the current facility, all records including the Medication Clinical Skills Checklist would transfer. -She did not know the Medication Clinical Skills Checklist was needed for Staff D at this facility.	D935		6-17-18 & On-going