PRINTED: 05/29/2018 FORM APPROVED

STATEMENT	of Health Service Regul For DEFICIENCIES OF CORRECTION	(x1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SU COMPLE	
		HAL080013	B. WNG		05/03	3/2018
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		
_		1915 MOC	RESVILLE RO	)AD		
CARILLO	N ASSISTED LIVING OF	SALISBURY SALISBUI	RY, NG 28147			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000	D. (1. 10.1 NGA G.12F. 0002		6-17-18
	The Adult Care Licer Annual survey on 05.	isure Section conducted an /01/18 to 05/03/18.		D 161 - 10A NCAC 13F .0903 Competency Validation for Ll Tasks		gu-doni
D <b>16</b> 1	For LHPS Tasks  10A NCAC 13F .050 Licensed Health Pro- (a) An adult care ho non-licensed person- not practicing in their governed by their pro- licensing laws are co- demonstration for an specified in Subpara Rule .0903 of this Su- performing the task of competency is assured oversight and super- This Rule is not met Based on interviews facility failed to assure (Staff D, Medication validated for License Support (LHPS) task thromboembolic decorate The findings are:  Review of Staff D's -She had transferred Medication Aide (Macurrent facility of 3/2)	nel and licensed personnel r licensed capacity as actice act and occupational competency validated by return r personal care task graph (a)(1) through (28) of abchapter prior to staff and that their ongoing red through facility staff vision.  It as evidenced by: and record reviews, the are that 1 of 6 sampled staff Aide)were competency and Health Professional as of applying and removing compression (TED) hose.  Dersonnel file revealed: d from a sister facility as a A) with a hire date at the	D 161	The facility will ensure that all licensed personnel and licensed practicing in the their licensed capacity as governed by their act and occupational licensing competency validated by return demonstration for any person task as required and specified Subparagraph (a)(1) through Rule .0903 of this Subchapter staff performing the task independently and their ongo competency is assured throug properly credential staff overs supervision.  Note: Carillon contends that the facility demonstrated substant compliance in this rule area. A identified in the statement of deficiencies, the Medication A competency was validated as documented on the LHPS dat 12/14/17 while working for Carilland and the competency was lightly the statement of the LHPS dat 12/14/17 while working for Carilland and the competency was lightly the statement of the LHPS dat 12/14/17 while working for Carilland and the competency was validated as the competency was validated as the carilland and the competency was validated as the competency was validated as the carilland and the	ed not I practice glaw are rn al care in (28) of prior to ing the he tial As Aide's	
	sister facilityThere was no docu	mentation a LHPS		Assisted Living in another fac	·	
Division of He LABORATORY	ealth Service Regulation / DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATUR	RE /	August Au	06	(XB) DATE

STATE FORM

461

J64(1) /

Reviewed and Accepted

Keisha Banks 07/02/2018

Div <u>ision</u> o	f Health Service Regu	<u>lation</u>	<del></del>	1	- 44 154 154
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE		'E \$URVEY MPLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING: _		
		HAL080013	B. WNG		5/03/2018
		TIALOGOOTO	<del></del>		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
			RESVILLE ROA	AD.	
CARILLO	NASSISTED LIVING OF	SALISBURY SALISBU	RY, NC 28147		
NA 10	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(xs)
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETE DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
		<u></u>	<u> </u>		
D 161	Continued From page	n 1	D 161	Validation regarding TED stocking	igs i _\n r
D 101	, -		·	were accomplished as well via	rgs 6-19-8
	competency validation	n was completed for the			
	current facility.			Medication Technician training a	1 1 11 1 1 1 1 1 1 1 1 1 1 1
				competency validation. To furthe	r   <b>0</b> , ,   ,
	Review of a LHPS co	ompetency validation	ľ	ensure compliance, the identified	
	provided by the Exec	cutive Director (ED) revealed		team member was re-validated fo	
		04/13/18 for the current			
1	facility.			skills competency by the Regiona	•
	Povlow of a resident	s Medication Administration		Nurse on 5/4/2017.	
	Departe /MAP) for M	March, and April 2018			
	revealed Staff D doc	umented removing TED		However, in an effort to ensure	
	hose on 03/06/18 03	3/07/18, 03/09/18, 03/14/18,	l l	·	
1	03/15/18 03/16/28 (	03/20/18, 03/21/18, 03/22/18,		100% compliance of this	ł
	03/23/18 03/28/18 0	04/01/18, 04/02/18, 04/03/18,		interpretation of this specific rule	
	04/05/18, 04/07/18, 0	04/09/18, 04/10/18, and		area and until the state can furthe	r l
	04/12/18.	•	1	clarify this standard of expectation	
	[			, -	
	Attempted telephone	interview with Staff D on		The facility will ensure all person	
1	05/03/18 at 3:00 pm	was unsuccessful.		are competency validated by retu	rn
	l		1	demonstration for any personal	
		ident Care Coordinator	j	care task including placing or	]
	(RCC) on 05/03/18 a	at 11:58 am revealed:	1	removing TED hose as required	
	- I ne Registered Nur	se (RN) was responsible for			
		competency validation was		upon hire or upon transfer from	
	completed for staff.	ency validations were		another Carillon facility although	
	Funnosed to be com	pleted during orientation to	ŀ	operating under the same	
	the facility.	brases desired estationary to		1 2	·
	-New MAs would no	to a 3 day class, train with		credentialing practices and prior	
	the supervisor, and	would have LHPS skills	.[	staff performing the personal care	
	checked off by the n		l	task independently. The facility w	ill
	-Staff D transferred t	to the current facility from a		ensure on-going competency of a	
	sister facility.			staff performing personal care tas	1
	-When Staff D transf	ferred to the current facility,	1	1 2	^
	her paperwork include	ding documentation of LHPS		through proper supervision and	
1	competency validation	on, was also transferred to	ł	oversight.	<b> </b>
] ,	the current facility.				
		of the LHPS process during			/
[·	orientation.				<b>\</b>
,	I		1	1	

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL080013 05/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1915 MOORESVILLE ROAD **CARILLON ASSISTED LIVING OF SALISBURY** SALISBURY, NC 28147 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX m (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) The Resident Care Director or other D 161 D 161 Continued From page 2 Carillon qualified representative will Interview with the Executive Director (ED) on 05/03/18 at 3:26 pm revealed: ensure the proper competency -Staff D transferred to the current facility from a validation is completed prior to staff sister facility. performing any personal care task -Staff transferred from facility to facility within the independently. same network quite often. -The RCC was responsible for ensuring that the LHPS competency validation was completed by The Resident Care Director and Executive Director and other She did not know a new LHPS competency validation was required for Staff D in the current personnel will conduct a weekly facility. review and audit of the staff training -She thought Staff D's paperwork, including the compliance tracker to ensure LHPS competency validation, could transfer to the current facility. compliance of this requirement. Interview with the regional Registered Nurse (RN) The Executive Director, Regional on 05/03/18 at 4:21 pm revealed: -She was filling in as the RN at the facility. Operations Director, Regional Nurse -She was responsible for completing the LHPS or other qualified personnel will competency validation for new staff at the facility. conduct an additional audit of -New staff shadowed her or the RCC and completed the LHPS competency validation personnel records monthly to ensure before they worked independently. further review and compliance with -If there were new staff transferring from another this requirement. facility in the network to the current facility, all records, including the LHPS competency validation, would transfer. -She dld not know a LHPS competency validation was needed for Staff D at this facility. D 234 10A NCAC 13F .0703(a) D 234 ,10A NCAC 13F .0703(a) Tuberculosis Test, D 234 Medical Exam & Immunizatio Tuberculous, Medical Exam & **Immunizations** 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each Upon admission to the adult care resident shall be tested for tuberculosis disease home, each resident will be tested for in compliance with the control measures adopted tuberculous disease in compliance

Division of Health Service Regulation

Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING 05/03/2018 HAL080013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1915 MOORESVILLE ROAD CARILLON ASSISTED LIVING OF SALISBURY SALISBURY, NC 28147 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X6) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) The Resident Care Director or other D 161 D 161 Continued From page 2 Carillon qualified representative will Interview with the Executive Director (ED) on ensure the proper competency 05/03/18 at 3:26 pm revealed: -Staff D transferred to the current facility from a validation is completed prior to staff sister facility. performing any personal care task -Staff transferred from facility to facility within the independently. same network quite often. -The RCC was responsible for ensuring that the LHPS competency validation was completed by The Resident Care Director and Executive Director and other -She did not know a new LHPS competency validation was required for Staff D in the current personnel will conduct a weekly review and audit of the staff training -She thought Staff D's paperwork, including the compliance tracker to ensure LHPS competency validation, could transfer to the current facility. compliance of this requirement. Interview with the regional Registered Nurse (RN) The Executive Director, Regional on 05/03/18 at 4:21 pm revealed: Operations Director, Regional Nurse -She was filling in as the RN at the facility. -She was responsible for completing the LHPS or other qualified personnel will competency validation for new staff at the facility. conduct an additional audit of -New staff shadowed her or the RCC and personnel records monthly to ensure completed the LHPS competency validation before they worked independently. further review and compliance with -If there were new staff transferring from another this requirement. 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 234 10A NCAC 13F .0703(a) D 234 D 234 10A NCAC 13F,0703(a) Tuberculosis Test, Tuberculous, Medical Exam & Medical Exam & Immunizatio Immunizations 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations Upon admission to the adult care (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease home, each resident will be tested for in compliance with the control measures adopted tuberculous disease in compliance

Division of Health Service Regulation

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI		SURVEY PLETED
AND PLAN (	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		]
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		HAL080013	B. WING		i/03/2018
		STREET AT	DORESS, CITY, ST	ATE ZIR CODE	
NAME OF P	ROVIDER OR SUPPLIER				
CARILLO	N ASSISTED LIVING OF	CALICRIEV	DRESVILLE RO	)AD	
<b>Φ</b> /((1220)		SALISBU	RY, NC 28147		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	jD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETE
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE	DATE
TAG	REGULATORI OR	EGO (DENTI) (ING III) CHIMA III CHI	1,70	DEFICIENCY)	1 1
				with the control measure adopted by	
D 234	Continued From page	∍3	D 234	the Commission for Health Services	as 6-19-18
	by the Commission fo	or Health Services as		specified in 10A NCAC 41A .0205	10-11-10
	specified in 10A NCA	C 41A .0205 including	1	1 -	<del>   </del>
	subsequent amendm	ents and editions. Copies of		including subsequent amendments	(X)-901/1
	the rule are available	at no charge by contacting	1	and editions.	
	the Department of He	ealth and Human Services,			1 0 4
	Tuberculosis Control	Program, 1902 Mail Service		The facility will answer any west land	<u> </u>
	Center, Raleigh, Nort	h Carolina 27699-1902.		The facility will ensure any resident	
	,			tested for tuberculosis disease prior	.0
	This Rule is not met			or upon admission to the facility.	
	Based on record revi	ew and interviews, the		,	
	facility falled to ensur	re 1 of 5 sampled residents		The Resident Care Director will veri	ا ا
		sted upon admission for			<sup>'y</sup>
	tuberculosis (TB) disa	ease.		documentation of the Tuberculosis	1
			Ì	Test prior to or upon arrival to the	
	The findings are:			facility. If there is no evidence via	1
		Mr. aumont El. 2 dated		valid record of current tuberculosis	
		#4's current FL-2 dated gnoses included avascular			
		steoporosis, depression,		test, The Resident Care Director will	
	chronic chetructive n	ulmonary disease, history of		complete a tuberculosis test upon	
	deep vein thrombosk	and chronic pain.	ነ	arrival to the facility. The Resident	i
	Geeb sell fillouinoor	o, and other pain		· · · · · · · · · · · · · · · · · · ·	
	Review of Resident #	44's Resident Register		Director or other qualified Carillon	
		mitted to the facility on		representative will further verify, for	
	01/28/16.	·	1	those prospective residents with a	
				documented history of a positive pp	1 1
	Review of Resident			reading, a chest x-ray is obtained	
	-There was a facility	generated form for		,	1 1
	documentation of Tu	berculin (TB) skin tests and		specifically ruling out signs and	
	Pneumonia vaccinati	ions.		symptoms of active TB and such	[ [
		nentation of any TB skin		documentation will be maintained in	,   <b> </b>
	tests completed.	and a graph of the first		the residents' records.	··
	-Written to the side of	if the form of where the first	ŀ	the residents records.	<u> </u>
	and second TB skin	tests should have been			
	documented was an	unsigned, hand-written note			
	which read, "Chest x	-ray done, [family member]	- [		
		[Resident #4] has a history		1.	
	of false positive TB to	ests." n was an x-ray report which	1	T <sup>*</sup>	}
	-Attached to the form	it x-ray was performed on			1
	Indicated that a ches	L X-I ay was periorified on		<u></u>	<u></u>

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	. IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	
		1				
		HAL080013	B, WING		05/0	3/2018
	<del></del>	<u> </u>				
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		1915 MOC	DRESVILLE ROA	AD D		ŀ
CARILLO	N ASSISTED LIVING OF	SALISBURY SALISBU	RY, NC 28147	_		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ч	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	UAIC	5,50
			_			
D 234	Continued From page	<del>3</del> 4	D 234			
				The Executive Director and		12-12-01
	1/12/16 due to a couç			Resident Care Director will		10 1
		not indicate any TB findings.			1	<del>}</del>
		bottom right side of the x-ray		conduct an audit of the resid		W-Wid
	report, with an illegible	le signature, was a note read, "No evideпсе of ТВ."		clinical record upon a reside	nt	~ ,
	There were no decur	nentation of a TB screening		admission verifying the requ	iired	U
	- Illete was no docum	ther TB testing in the record.	}	tuberculosis test has been		<b>.</b>
	questionalle or any o	met 15 testing in the reserve				
	Review of a verbal or	rder form dated 05/02/18 at		completed. The Executive D		
	1:40 pm revealed:		1	and Resident Care Director:	will	·
		orted history of positive		review the Clinical Complian	nce	1
	purified protein deriva	ative (PPD) reading.		tracking to review complian		
	-Rule out active TB b	y x-ray (chest) only.		1 0 1	LE OII a	
		orders regarding TB testing	1	weekly basis.		
	or chest xrays to rule					
				The Executive Director, Reg	ional	
	Interview with the Ex-	ecutive Director (ED) on		Operations Director, Region		
	05/02/18 at 1:45 pm			, ,		
		Resident #4's physician's		Nurse or other qualified Car	illon	ļ , l
		no documentation of a	ŀ	representative will conduct		
		the physician's office.	1	monthly audits of resident re	ecords	
		he Rowan County Health		1		
		had no documentation of a		to ensure compliance with the	.118	
	positive TB skin test.		ł	requirement.		
		050/3/49 of 3:36 pm	1			
	Interview with the ED   revealed:	on 050/3/18 at 3:26 pm	1			ļ
		se (RN) was responsible for				
	administering TB skir					
		le to locate documentation of				į l
		tests prior to Resident #4's	1			
	admission to the facil					ľ
		ents were admitted to the	1			
		would have a TB skin test	1			
	prior to being admitte		1	1		
	TB skin test within 14		1	1		
		nding Resident #4 was	1			
	covered for TB skin a	as long as she had had the	1 .			
-	chest x-ray prior to a	dmission to the facility.	1			
	1		1	1		1

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 05/03/2018 9. WING HAL080013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1915 MOORESVILLE ROAD CARILLON ASSISTED LIVING OF SALISBURY SALISBURY, NC 28147 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 234 Continued From page 5 D 234 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 D 273 admitted into the facility. -The last time she had a TB skin test was about 10A NCAC 13F .0903(b) Health Care 10 or more years ago when she was working. -"They said I am a carrier." The facility shall assure referral and -She was not sure, but she thought her last TB follow-up to meet the routine and skin test was negative. acute health care needs of residents. D 273 D 273 10A NCAC 13F .0902(b) Health Care For the specific resident identified, the 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up community followed up with the to meet the routine and acute health care needs physician that had placed the of residents. 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 This Rule is not met as evidenced by: administered to the resident as Based on observations, interviews, and record reviews, the facility failed to notify the physician prescribed.

Division of Health Service Regulation STATE FORM Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 05/03/2018 HALQ80013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1915 MOORESVILLE ROAD CARILLON ASSISTED LIVING OF SALISBURY SALISBURY, NC 28147 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 273 D 273 Continued From page 6 The facility will ensure all new for 1 of 5 sampled residents (Resident #1) orders including orders involving a regarding a medication used to treat Parkinson's delayed start; hold or time-limited disease. medication orders are verified upon The findings are: receipt of the order. The Resident Care Director or other qualified Review of Resident #1's current FL2 dated 07/11/17 revealed: Carillon representative will verify -Diagnoses included dementia with behavioral the medication including disturbance. confirmation of the order -She was constantly disoriented. -There was an order for Rytary 23.75mg-95mg documented on the resident Extended Release (ER) capsules (used to treat medication administration record, symptoms of Parkinson's disease such as clarification of any questions tremors), 1 capsule three times a day at 8:00 am, 1:00 pm, and 6:00 pm. regarding the resident order through follow-up with the Review of Resident #1's subsequent physician's resident's prescribing physician and orders dated 10/19/17 revealed: -A diagnosis of Parkinson's disease. a pharmacy representative. -An order for Rytary 23.75mg-95mg ER capsules, 1 capsule twice a day at 8:00 am and 6:00 pm. The facility in partnership with the Review of Resident #1's medical record revealed assigned pharmacy will conduct a a verbal order dated 11/21/17 to hold Rytary review of the medication order 23,75mg-95mg ER capsules until prior verification process within Carillon authorization was obtained from the provider. and the pharmacy to identify any Review of Resident #1's November 2017 areas for improvement in the electronic Medication Administration Record medication verification process. (eMAR) revealed: -An entry for Rytary 23.75mg-95mg ER capsules, take 1 capsule twice a day at 8:00 am and 6:00 - 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

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_ B. WING 05/03/2018 **HAL080813** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1916 MOORESVILLE ROAD CARILLON ASSISTED LIVING OF SALISBURY SALISBURY, NC 28147 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) D 273 D 273 Continued From page 7 am and 6:00 pm from 11/19/17 through 11/30/17. The Executive Director, Resident - Rytary 23.75mg-95mg ER capsules were Care Director and other qualified marked as discontinued on 11/30/17. Carillon representative will Review of Resident #1's December 2017 conduct weekly audits of the electronic Medication Administration Record clinical record including review of (eMAR) revealed Rytary 23.75mg-95mg ER capsules had been removed from the eMAR. any new orders to ensure medication verification and timely Based on observation and record review, it was follow-up with the resident determined that Resident #1 was not interviewable. physician has been completed as required. 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 The Executive Director, Regional had never seen it listed on the eMAR. Operations Director, Regional -She had never given Rytary to Resident #1. Nurse or other qualified Carillon Telephone interview on 05/03/18 at 12:45 pm with representative will conduct the facility's contracted pharmacy revealed: monthly audits of resident clinical -The Rytary medication had been placed on hold records to ensure compliance with by the pharmacy in November. -There was a signed verbal order from the this requirement. 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

Division of Health Service Regulation  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL080013	B. WING		05/03/2018
			ADDRESS, CITY, STAT	E. ZIP CODE	
NAME OF PI	ROVIDER OR SUPPLIER		OORESVILLE ROA		
CARILLO	N ASSISTED LIVING OF	CALICDIDV	URY, NC 28147		211
(X4) ID PREFIX TAG	/FACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETE
D 273	Continued From pag	e 8	D 273		1-17-18
	as a one-time emerg	ency fill through the	1 1		ΙΨ., Ρ
	insurance company	on 05/03/18 but it would			<del>}</del>
	require prior authoriz	ation for any refills			The sale
1	thereafter.				U Pq yv
	-He would inform the	facility that the prescription	-		
	was filled as an eme	rgency fill that day	<b> </b>		1
	(05/03/18).		l		
	Telephone interview	on 05/03/18 at 2:49 pm with #1's primary care provider's			
	(PCP) office revealed	4.1 & buildark cale broader a			
	Resident #1's PCP	had not prescribed the			
	Rytary, it had been to	prescribed by a Parkinson's			
	disease specialist.	•			
	-Since he did not pre	escribe the medication, refill			
	requests were not se	ent to his office.	1		
	-Since he did not red	ceive any requests for the			
		ot know that the resident had			•
	not been receiving it	:. contacted his office regarding	į į		1
	the medication since	November when he gave a			
	verbal order to hold	it until insurance approved.			
	-The pharmacy had	not contacted his office			l l
	regarding any prior	authorizations for the			}
	medication.		1 1		ì
	-The medication was	s used to treat the symptoms			
	of Parkinson's disea	se, such as tremors.			
		for the Parkinson's disease			1 1
	specialist was not a	vallable.	- [		
	Telephone interview	on 05/03/18 at 3:00 pm with			
i	Resident #1's family	member revealed:	]		
1	-She did not know ti	hat Resident #1 was not			
	receiving the Rytary	medication.		1	
	-The resident had b	een prescribed the			
1	medication to contro	ol progression of her	İ		
1	Parkinson's disease	).			
	-The facility had not	contacted her regarding the		<u>'</u>	<b> </b>
1	need for prior author	rization for the medication.			
1	I -The facility had not	Informed her that the resident	1		

	of Health Service Regul TOF DEFICIENCIES	(x1) PROVIDER/SUPPLIER/CLIA	(X2) MULT(PLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL080013	B. WNG		05/03/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY <b>, ST</b> A	TE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	SALISBURY	ORESVILLE ROA JRY, NC 28147	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
D 273	Continued From page	9	D 273			
	2017The pharmacy had r needing prior authorit	ication since November not contacted her regarding zation for the medication.				
	pocket for the medica would receive it.	would have paid out of ation so that Resident #1		·		
	asked for emergency -She was working to delivered to the facili -There was no order medication in the res -The medication was	ED) revealed: the provider's office and authorization for Rytary. have the medication ty as soon as possible. to discontinue the				
	eMAR at the end of the The facility did not k	now that the pharmacy did ue order for the medication				
	a nurse at Resident i office revealed: -The Rytary medicati another generic vers insurance on 05/03/1			-		
	-The new order had the re 05/04/18.	been sent to the facility and sident had received it on		D287 10A NCAC 13F .0904(b)(2) Nutrition and Food Service	6-17-18	
D 287	Service	4(b)(2) Nutrition And Food	D 287	The facility will ensure table so	1 1 1	
	10A NCAC 13F .090 (b) Food Preparation	4 Nutrition And Food Service n and Service in Adult Care		will include a napkin and non disposable place setting consist		

	<u>if Health Service Regu</u>	lation	T (VO) AM II TIDI E	CONSTRUCTION	(X3) DATE SUF	RVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLET		
AND LIMIT	A COMPLETION		A. Bottomo:				
		HAL080013	B. WNG			/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE			
1915 MOC			RESVILLE RO	AD			
CARILLO	N ASSISTED LIVING OF	SALISBURY SALISBUF	RY, NC 28147		<del></del>		İ
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 287	Continued From page Homes: (2) Table service sha non-disposable place a knife, fork, spoon, possible containers. Exception individual basis and documented needs of resident.  This Rule is not met based on observation failed to provide a place in the findings are:  Observations during on 05/01/18 at 10:55-A resident lying in the on her stomach from the plate included 90% of, a bowl of oa at slice of toast cut in the resident to page in the content of the plate included the content of the plate included the content of the plate included the content of the c	e 10  Ill include a napkin and e setting consisting of at least plate and beverage ns may be made on an shall be based on or preferences of the  It as evidenced by: ns and interviews, the facility ace setting which included a d beverage container for their rooms.	D 287	of at least a knife, fork, spoon and beverage containers. The will ensure non-disposable silverware, plate and cups I us serve breakfast, lunch or dinn the main dining room, as pref by the resident in their person rooms or other common space community.  Immediate in-servicing began 5/3/2018 for all staff to ensure understanding of state require. This will continue ongoing to new hired employees are educed Disposable dishware and uten will only be used in such cases documented request by reside direction by physician or as warranted for infection control illness.  The Dining Services Manager	ed to er in erred al e in the ensure cated. sils as ent, ol due	.y-g0	18
	Observation of the li residents who were 05/01/18 at 12:45 pi One resident ate in baked ham, roasted orange juice, and te -The orange juice a disposable cups wit	her room and was served I potatoes, spinach, a roll, ea. nd tea were served in h ilds.		Resident Care Director and Executive Director will ensure Meals are plated on non-dispolates, drinks are in non-dispocups and non-disposable silve is provided for all meals.	osable osable erware		
,	-A plastic spoon wa meal.	s provided with the lunch		All facility staff and managem	ient		

STATEMENT	of Deficiencies  From Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SU COMPLE		
		HAL080013	B. WING		05/0	3/2018	
			DUESE CITY STA	E 710 CODE			
NAME OF PA	ROVIDER OR SUPPLIER		DRESS, CITY, STAT				1
CARILLO	NASSISTED LIVING OF	SALISBURY	RESVILLE ROARY, NC 28147				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	∃E,	(XE) COMPLETE DATE	
D 287	Continued From page Interview with the res revealed: -She would prefer to be drink from a cup or gloupShe was brought play when she ate in her residents who were so 05/02/18 between 8:3 -There were three restrooms for the breakfar -One resident was seand a bowl of cereal. coffee and orange juicups with disposable non-disposable forkA second resident was toast, bacon, and a be included coffee and disposable cups with included a non-disposable cups with included a non-disposable toast. The beverages	ident on 05/01/18 at 2:59 pm have sliverware to use and ass and not a disposable stic utensils with her meals com. of plastic spoons in her ded with her meals. eakfast meal service for erved in their rooms on 30 and 8:50 am revealed: sidents who ate in their list meal. erved a plate of eggs, toast, The beverages included ce served in disposable lids; utensils included a as served a plate of eggs, owl of grits. The beverages orange juice served in disposable lids; utensils	D 287	staff will be re-in-serviced or non-disposable silverware, composed and plates for all meals. The Executive Director, Resistant Care Director and other quancarillon representative will conduct weekly review of medivery at different times to compliance with this require. The Executive Director, Region Nurse or other qualified Carrepresentative will conduct monthly audits of resident reto ensure compliance with the requirement.	ups, s. ident lified eal ensure ement. ional ial cillon	6-17-1	8
·	lids; utensils included Interview with the res their rooms for the br 05/02/18 between 8:3 -"I would rather have	I a non-disposable fork. Idents who were served in eakfast meal service on 30 am and 8:50 am revealed:		·			
	what they give me." -"I don't know why the -"They usually send a always send paper o	ey gave me this fork." a plastic spoon and they					

, STATE FORM

STATEMENT	or <u>Health Service Requ</u> FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE GO A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL080013	B. WING		05/03/2018
NAME OF P	ROVIDER OR SUPPLIER		ORESVILLE ROAL		
CARILLO	N ASSISTED LIVING OF	SALISRIBY	JRY, NC 28147		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 287	Continued From page	a 12	D 287		6-17-18
	-"I keep a plastic knif	e that I wash and reuse."			ي
	05/02/18 between 12 revealed: -There were two resi for the lunch mealOne resident was so tomato soup, and a biserved in 2 disposability silverware included a wrapped in a paper the second resident garlic toast, and a briserved in 2 disposability.	served in their room on 1:25 pm and 12:45 pm  dents who ate in their room  erved a sandwich, a bowl of prownie. The beverages were ale cups with disposable lids; a non-disposable spoon owel. t was served lasagna, salad, ownie. The beverages were ale cups with disposable lids; a non-disposable fork			ongoine
	05/02/18 at 2:33 pm -She assisted in the breakfast and lunch -She sometimes pre ate in their roomShe picked up a res the kitchen and put i dessert, drinks, and in a paper towel"Some residents do want plastic forks, k -Beverages were pu tid was placed on th -The paper cups and serving station in the Interview with a sec pm revealed:	dining hall during the meal services. pered trays for residents who sident's prepared plate from ton the tray along with a plastic or silverware wrapped on't want silverware. They nives, and spoons". It in a paper cup and a plastic paper cup. It id ids were kept behind the edining room.			

STATE FORM

Division o	of Health Service Regu	<u>lation</u>			(X3) DATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co		COMPLETED
AND PLAN (	OF CORRECTION	DEMINIONION NOMBER	A. BUILDING:		
				İ	a sinning i a
		HAL080013	B. WING		05/03/2018
NAME OF D	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	
		1915 M	OORESVILLE ROAL		
CARILLO	N ASSISTED LIVING OF	SALISBURY	URY, NC 28147		
	<del></del>		<del></del>	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD B	IE, COMPLETE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI	ATE DATE
				DEFICIENCY)	
D 207	Continued From pag	<u> </u>	D 287		1 in the
D 287	Continued From pag	6 13			10-1,1-18
		s taking trays to residents	1 {		ייַש
	who ate in their room	n during each meal.			<i>E</i>
		a tray to take to a resident's	1		404
		the prepared plate of food	1 1		W)-40K
		also included beverages	-   -		
	and silverware.	1 46 AP Ar			
	-"We normally put re	gular silverware on the tray,			
		is none washed when we	-		
	take it to the room.	-t	1		
	-She knew all reside		- 1 - 1		
	non-disposable slive	ays and delivered the meals			
	to the residents who	ate in their rooms for the			
	lunch meal service to				
	The resident who w	as served lasagna was given			
	a non-disposable for	k and a knife wrapped in a			
	naper towel and was	served beverages in paper			
	cups.				
	-The resident who w	as served soup and a			
1	sandwich was given	a non-disposable spoon			
	wrapped in a paper	towel and was served			
	beverages in paper		-		
1		etary Manager (DM) on			į l
	02/02/18 at 2:46 pm	revealed:	1		·
	-She knew all reside	ents should receive a			
1	non-disposable plac	e setting with their meals.			
	-She did not know w	hat silverware and cups the			
		on the trays for residents who			
	ate in their rooms.	re and cups in the kitchen			
	- I nere was silverwa	supposed to pick up when			
	they came to the left	chen to pick up the plated			
	food for residents w	ho ate in their rooms.			
	She did not know F	CAs were preparing the trays			i l
Į.	with paper cups and				1
		plastic spoons back here."			
	- Paper curs and pla	stic lids were kept behind the			\
ŀ	serving station in the	e dining hall.			
	-"We're going to have	ve a meeting about that one."			

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 1 B. WING 05/03/2018 HAL080013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1915 MOORESVILLE ROAD CARILLON ASSISTED LIVING OF SALISBURY SALISBURY, NC 28147 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 287 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 napkln 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 -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 half during the dinner -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.

Division of Health Service Regulation

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: B. WING 05/03/2018 HAL080013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1916 MOORESVILLE ROAD CARILLON ASSISTED LIVING OF SALISBURY SALISBURY, NC 28147 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 287 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." D309 10A NCAC 13F .0904(e)(3) D 309 D 309 10A NCAC 13F .0904(e)(3) Nutrition and Food Nutrition and Food Service Service 10A NCAC 13F .0904 Nutrition and Food Service All diet orders were verified by (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and Regional Nurse and Dietary current listing of residents with physician-ordered Tracker updated to ensure accuracy therapeutic diets for guidance of food service on 5/4/2018. staff. This Rule is not met as evidenced by: The facility will maintain an Based on observations, interviews, and record accurate and current listing of reviews, the facility failed to ensure an accurate residents with physician-ordered and current listing of residents with physician-ordered therapeutic diets was available therapeutic diets for guidance of for guidance of food service staff for 1 of 6 food service staff. residents sampled (#2).

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 05/03/2018 B. WING HAL080013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER. 1915 MOORESVILLE ROAD CARILLON ASSISTED LIVING OF SALISBURY SALISBURY, NC 28147 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY The facility will ensure all new D 309 D 309 Continued From page 16 orders including orders involving new diet orders including changes in The findings are: consistency are verified upon receipt Review of Resident #2's current FL2 dated of the order. Upon verification of 01/08/18 revealed: the new diet order the Resident Care -Diagnoses Included dysphagia and dementia. Director, Resident Care Coordinator -There was a physician's order for a regular diet or other qualified Carillon with ground meats. representative will adjust the Dietary Review of the therapeutic diet list posted in the Tracking log listing the resident diet kitchen on 05/01/18 revealed Resident #2 was to orders and provide to the dietary receive a regular diet with no indication of ground staff to ensure timely guidance and meats. compliance with the most recent Review of an updated therapeutic diet list posted diet order. in the kitchen on 05/02/218 revealed Resident #2 was listed as being on a regular diet with ground meats. The Executive Director, Resident Care Director or other qualified Interview on 05/02/18 at 8:45 am with a first shift personal care aide (PCA) revealed: Carillon representative will -Resident #2 had been receiving regular meals. Conduct weekly audits of the -She did not know Resident #2 had an order for resident record to include review of ground meals until a PCA brought Resident #2 ground bacon at the end of the breakfast meal on the most recent dietary order and 05/02/18 and the dietary manager came to the dietary tracker to ensure a current dining room to inform all the staff. and accurate account of all resident Interview with the Executive Director (ED) on diets. 05/03/18 at 9:05 am revealed: -The Resident Care Coordinator (RCC) and the The dietary staff will be in-serviced regional Registered Nurse (RN) reviewed the on the dietary tracker to reiterate therapeutic diet list weekly. -The diet list was updated when a new resident awareness and use to ensure proper moved in and when residents had changes in service delivery and compliance with their diet orders. -Resident #2's order for a regular diet with ground all diet orders. meats had been verified by her primary care -She had not known the therapeutic diet list did

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Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ B. WING 05/03/2018 HAL080013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1915 MOORESVILLE ROAD CARILLON ASSISTED LIVING OF SALISBURY SALISBURY, NC 28147 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY The Executive Director, Regional D 309 Continued From page 17 D 309 Operations Director, Regional not match the physician's order for the Nurse or other qualified Carillon therapeutic diet for Resident #2. -Resident #2's diet order had been updated on representative will conduct the therapeutic diet list as a regular diet with monthly audits of resident records ground meats. to ensure compliance with this Interview with the Special Care Unit (SCU) RCC requirement. 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 dlet 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

STATEMENT	IN OF DEPOSITOR		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY PLETED
		HAL080013	B. WING	B, WING		/03/2018
-	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STATE DORESVILLE ROAI URY, NG 28147			
(X4) 1D PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMFLETE DATE
D 309	each resident and or resident was on by relist.  -She had received at today (05/03/18) and changed from a regular ground meats on the Telephone Interview Resident #2's primal revealed Resident # which was why she which was why she which was why she which was why she which was why she which was why she which was why she which was why she which was why she which was why she which was why she which was determined Resident #2's family #2's diet was changed to a regular diet to a regular diet she was admitted to Interview with the reproduction of the resident's recompared it to the compared it to the	pies of the diet orders for ally knew what diet each evlewing the therapeutic diet in updated therapeutic diet ilst il Resident #2's diet was allar diet to a regular diet with extension 05/03/18 at 11:30 am with ry care provider (PCP) 2 had a history of dysphagia needed ground meats.  On 05/03/18 at 12:20 pm with rember revealed Resident extension a mechanical soft with grounds meats when the facility.  Equipment of the facility when a resident er or when a new resident ity. Included reviewing and eatic diet list when a resident er or when a new resident ity. Included by the physician in d.	D 309			0-17-18 0n-90h

Division of	f Health Service Regu	ation	<del>,</del>	la la	(O) DATE CHENCEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	COMPLI		(3) DATE SURVEY COMPLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		
		HAL080013	fi. WNG		05/03/2018
	, , , , , , , , , , , , , , , , , , ,	etect Ann	RESS, CITY, STA	TE ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				
CARILLO	ASSISTED LIVING OF	SALISBURY	RESVILLE ROA	AD.	
-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		SALISBUR	Y, NC 28147		
(X4) 1D		ATEMENT OF DEFICIENCIES	iD DBBBBB	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETE
PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	·
IAG	HELDER HOW OF C	,		DEFICIENCY)	
			D 310	D310	7
D 310	Continued From page	e 19	0310		6-17-18
D 310	10A NCAC 13F .0904	(e)(4) Nutrition and Food	D 310	10A NCAC 13F .0904(e)(4)	4
	Service			Nutrition and Food Service	(A) (N)
					U TOM
		Nutrition and Food Service		Immediate re-education for all	staff U
	(e) Therapeutic Diets	s in Adult Care Homes:		was initiated on 5/4/2018 to en	
	(4) All therapeutic die	ets, including nutritional		1	Suite
	supplements and thic	kened liquids, shall be		understanding of physician	
	served as ordered by	the resident's physician.		prescribed therapeutic diets, w	
				to locate such information and	the
,				requirement to serve diets as	l l
	This Rule is not met	as evidenced by:		prescribed. This training will be	20
		ns, interviews, and record		1 -	, ,
	reviews, the facility fa		-	ongoing for newly hired emplo	yees.
		n order for a regular ground		The facility will ensure all	1
	meat dlet was served			therapeutic diets; including	
				nutritional supplements and	
	The findings are:			thickened liquids will be served	1 00
	  -	(E) (E) (E) (E) (E) (E) (E) (E) (E) (E)		<u> </u>	
		2's current FL2 dated	1	ordered by the resident's physi-	cian.
	01/08/18 revealed:	demands and domentia			
	-Diagnoses included	dysphagia and dementia. an's order for a regular diet	ļ	The Resident Care Director,	
	with ground meats.	all 5 Older for a regular diec		Resident Care Coordinator of	other
	With Ground Ineats.		1	1	1
	Review of the diet lis	t posted in the kitchen dated		qualified Carillon representativ	/e wш
	05/01/18 revealed Re	esident #2 was ordered a		ensure all new diet orders are	
		nention of ground meats.		verified upon receipt including	
ļ		-		changes in diet or diet orders u	pon
		1/18 from 11:45 am to 1:00	1	admission of a new resident.	r
	pm of the lunch mea	service revealed:		admission of a new resident.	
		consisted of two whole slices			
	of baked ham, large	diced roasted potatoes,		The Resident Care Coordinato	r,
}	greens, a dinner roll,	a slice of pecan pie, a glass	ĺ	Resident Care Director or othe	r
ł		ea, and a glass of milk.		qualified Carillon representative	ze will
	- The nam was not cr	nopped, cut up or ground. up the ham slices with her			
	hands and bit them.	uh the tight suces with her		update and verify all new order	
		not chew, and spit it into her		listed on the resident dietary tr	acker
1	hand and placed it b				
Ī	I train and biaced it p	MALL ALL RICE PROPERTY.		<u> </u>	<del></del>

Division o	f Health Service Regu			e en inventorious	(VALDATE PI	IBV/EV
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	<del></del>	[	
					1	
		HA1 090042	B. WING		05/0:	3/2018
		HAL080013	1			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	re, zip code		Ţ
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1915 MOO	RESVILLE ROA	a/		
CARILLO	N ASSISTED LIVING OF	QALIQRI IDV	Y, NC 28147			
		- GALIOBOI	1 1	DE CUITE DE LA MISE CORRECTIO		otes .
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI		DATE
TAG	REGULATOR! OR	ESCIDERTIA PIACIFIA STABILICA	IAG	DEFICIENCY)		
			<del>                                     </del>	an armin a the meant armunt a	n d	
D 310	Continued From page	e 20	D 310	ensuring the most current a		61718
				accurate list of resident diets	upon	DILLA
		ned only 10% of the meal	1	receipt of a new diet order.	Γhe	50n
	and only 3 bites of ha	am.		_		, 62. 2
			į l	Resident Care Director, Resi		going
		2/18 from 7:50 am to 9:15	1	Care Coordinator or other o	ualified	ال ( ,
		neal service revealed:	1	Carillon representative will		$\smile$ $\mid$
		consisted of scrambled				ı
	eggs, a bowl of grits,	two whole silces of regular		the updated and current die	tary	
	bacon, two slices of	toast, two glasses of milk,		tracker is provided to the die	etarv	
i	one class of orange	juice, and one glass of water.	ŀ	staff upon change of any res	•	
	The bacon was not g		1	,	ident	
		ned 75% of the meal but	<b>\</b>	diet.		'
	only 2 bites of the ba					
	-The resident demon	strated difficulty chewing the		The Executive Director, Res	idont	
	bacon slices as she	could not tear it apart with		· · · · · · · · · · · · · · · · · · ·		
	her teeth when she t	oit into the bacon.		Care Director or other quali	fied	
		e of bacon, the resident		Carillon representative will		'
1	placed the bacon on	the plate and did not attempt	1	1 -		
	to bite it again.	tio pieto are es moramente		Conduct weekly audits of th		
	At the end of the me	eal, a PCA brought a bowl of		resident record to include re	eview of	ţ
Į.	-At the end of the the	he kitchen and the resident	]	the most recent dietary orde	rand	ļ
ľ				1		
	ate three spoons or	ground bacon with grits.	1	dietary tracker to ensure a c	urrent	
		0 at 0.45 am with the distant	1	and accurate account of all 1	esident	
		8 at 8:45 am with the dietary	1	diets.	= *	
	manager revealed:		.]	diets.		<b>!</b>
		esident #2 had a diet order	Į.			
	for ground meats da	ted 01/08/18.		The Executive Director, Reg	rional	
•	-She had received the	ne order for regular diet with		_		ŀ
		norning (05/02/18) from the		Operations Director, Region		ļ
	Executive Director (1	ED).		Nurse or other qualified Car	rillon	
	-She did not have at	n order for ground meats for	,	representative will conduct:		
	Resident #2 prior to	the one the ED had given her		) <del>-</del>	-	
	that morning			audits of resident records to		
	-Resident #2 would	receive ground meats at each		compliance with this require	ement.	
	meal starting today	(05/02/18).	1	'		
	-Resident #2 had be	en served a regular diet	1	<b>\</b>		1
	since being admitted	d to the facility on 01/11/18.	1			
		•	1			
[	Interview on 05/02/1	8 at 8:45 am with a first shift	1			}
	personal care aide (		1			
1	Resident #2 had be	en receiving regular meals.	1			1
1	I LIZEGIOGIST ME HOO DE	ANTI-CONTENS TOSSICE THEORY.				<del></del>

Division o	f Health Service Regu	lation		<del></del>	turn Darre Old Driver
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL080013	B. WING		05/03/2018
NAME OF D	POWER OF CLUBBLICE	STREETAD	DRESS, CITY, STATE	E, ZIP CODE	
	ROVIDER OR SUPPLIER	1916 MOC	ORESVILLE ROAL	ם	
CARILLO	N ASSISTED LIVING OF	OALICDUOV	RY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETE
D 310			D 310	•	61H8
	ground meats until at	esident #2 had an order for nother PCA brought Resident			m-
	#2 ground bacon at t today (05/02/18) and to the dining room to	he end of the breakfast meal the dietary manager came inform all the staff.			going
	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 05/01/18Once she knew, she had contacted Resident				
				•	
<b>L</b>					
1	#2's primary care pro 05/01/18 to get clarif	ovider the evening of ication on diet orders.			
	-She decided to ask resident had not bee	for clarification since the in receiving the diet on the			
		r diet orders after the FL2			
	from 01/08/18The diet order on the missed at admission	ne FL2 had somehow been	•		
	-She had received a	diet order clarification from that morning (05/02/18), in			
	answer to her reque	st, documenting that receive a regular diet with		·	
	ground meatsShe had informed t	he dietary manager when the		,	
	therapeutic diet met	the order was added to the nu. receive ground meats at each			
	meal starting with th	le lunch meal today 05/02/18.			
	shift PCA revealed:	18 at 4:25 pm with a second			
	#2 was supposed to	out that afternoon Resident receive a regular diet with			
	ground meatsResident #2 had be previously.	een on a regular diet			
ì					

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<u>Division o</u>	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL080013	B. WING		05/03/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
		1915 MC	ORESVILLE ROA	D	
CARILLO	N ASSISTED LIVING OF	SALISBI	JRY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETE
D 310	Continued From page	22	D 310		10-17-18
	Resident #2's primary revealed: -He had written an orground meats on 05/6 request for clarificatio -Resident #2 had a hi was why she needed -He had not written R 01/08/18, it was compresident's prior facility -The resident had beat her previous facilityHe had not received resident's family with had difficulty with the -He had seen the resident once in MarchHe did not feel that ti	der for a regular diet with 02/18 after he received a in from the facility. Istory of dysphagia which ground meats. esident #2's FL2 dated beted by a provider at the factor on a mechanical soft diet on on a mechanical soft diet on that was not offered at any reports from staff or the any concerns the resident regular diet. Ident twice, once in January the resident had any negative ceiving ground meats prior			90-90-N
	Resident #2's family racesident #2 had movement another facility on 01/2. Resident #2 had been at the previous facility and swallowing.  The current facility disort diet so Resident it to a regular diet with garden and the swally came to various to sandwiche "she was able to eat the meals."  He did not know Resident #2's family f	ved to the facility from /11/18. In on a mechanical soft diet v due to difficulty chewing id not offer a mechanical #2's diet had been changed			

STATEMENT	f Health Service Regu of DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA  DENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SUF COMPLET		
		HAL080013	B. WING		05/03/	/2018	
	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA DRESVILLE ROARY, NC 28147				
(X4) ID PREFIX TAG	ÆACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
	10A NCAC 13F .100  10A NCAC 13F .100  (a) An adult care ho the resident's physic for verification or clamedications and treat (1) if orders for admiresident are not date of admission or readd (2) if orders are not (3) if multiple admission or readmission or rea	2(a) Medication Orders  2 Medication Orders  me shall ensure contact with ian or prescribing practitioner rification of orders for atments: ssion or readmission of the ad and signed within 24 hours imission to the facility; clear or complete; or sion forms are received upon ission and orders on the me. sure that this verification or mented in the resident's	D 344	D344 10A NCAC 13F .1002(a) Med Orders. On 5/4/2018, The Regional Notes received a clarification order resident identified. Communication identified as writtens reviced Med Techs on clarification will be reviewed RCD, RCC and/or ED to ensure proper clarification is completed as a complete facility will ensure all new including orders received upon admission or readmission are upon receipt of the order. The Resident Care Director or other qualified Carillon representative verify the medication including confirmation of the order documented on the resident medication administration resident redication administration resident medication administration resident medication administration resident resident medication administration resident medicat	for the for the nity n and inity daily by ure eted. w orders on e verified her tive will ing	6-17-16 On-90	S
	05/14/17 revealed of hypertension, atrial mellitus type 2.	diagnoses included fibrillation, and diabetes quent physician's order dated		clarification of any questions regarding the resident order follow-up with the resident's prescribing physician and a	through		
	05/30/17 revealed a blood sugar (FSBS	an order to check finger stick ) 2 times a day.		pharmacy			
1	Review of Residen	t #5's record revealed	ł			<u> </u>	

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STATEMENT	of Health Service Regul FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLANC	A CONNECTION		7, 10/LD/10/		
		HAL080013	B. WING		05/03/2018
NAME OF P	ROVIDER OR SUPPLIER	\$TREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
•		1915 MOC	ORESVILLE ROA	AD	·
CARILLO	N ASSISTED LIVING OF	SALISBURY SALISBU	RY, NC 28147		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 344	subsequent signed p 10/30/17 to check FS administer 25 units of morning.  Review of Resident is orders revealed order follows: -On 11/08/17, incread dailyOn 01/04/18, incread dailyOn 02/22/18, incread dailyOn 03/28/18, incread dailyOn 03/28/18, incread daily. Review of a subseq 2/22/18 revealed: -An order for Novolo injectable medication per sliding scale 3 ti instructedThere was no assist Insulin to administer (SSI) ordered with F Review of Resident Medication Administ revealed: -There was an entr sugar before breakt 4:30 pmThe resident's bloc 385There was an entr section of the eMAI times a day before	hysician's orders dated SBS 2 times a day and if Lantus insulin every  #5's subsequent physician's ars for Lantus insulin as se Lantus insulin to 31 units ase Lantus insulin to 38 units ase Lantus insulin to 44 units ase Lantus insulin to 60 units ase Lantus insulin to 70 units ase Lantus insulin to 70 units uent physician's order dated og insulin (a rapid acting on used to lower blood sugar) imes daily, prior to meals as gned amount of Novolog of for the sliding scale insulin	D 344	representative. The Resider Director, Resident Care Coordinator or other quality Carillon representative will any clarification of medicate orders are documented acceptance in the resident's clinical recompleted and other quality carillon representative will weekly audits of the clinical including review of any new to ensure medication verificand timely follow-up with resident physician has been completed as required.  The Executive Director, Region Nurse or other qualified Carepresentative will conduct monthly audits of resident records to ensure compliant this requirement.	fied lensure tions ordingly cord.  esident halified l conduct el record w orders ication the h egional onal arillon t clinical
Division of I	lealth Service Regulation		6859	7.18411	If continuation sheet 25 of 4

STATEMENT	of Deficiencies OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
7,1151 551			TO BOILDING:			
		HAL080013	B. WING		05	/03/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DORESS, CITY, STATI	E, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	SALISBURY	ORESVILLE ROA	<b>D</b> ,		
CARILLO		- OALIOD	URY, NC 28147		COORDECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 344	Continued From pag	e 25	D 344			1 17 18
	as needed beginning	02/12/18 with no scheduled	1			(D-1 1-19
		on and no parameters.				<i> </i>
	D. J at the March	2018 eMAR for Resident #5				Da CAN IN
	Review of the iviation	ZUTO GIVIAR TOT RESIDENTA	i 1			CA-dalis
	-There was an entry	for check and record blood				
	sugar before breakfa	st and dinner at 7:30 am and				
	4:30 pm.	d sugar ranged from 141 to	1			
	429. (Resident #5's i	primary care physician was				
	contacted for elevate	ed blood sugar).				
	-There was an entry	In the "prn (as needed)"				1
	section of the eMAR	for Novolog insulin Inject 3				
ļ	times a day before in	neal(s) as directed, per SSI, g 02/12/18 with no scheduled				
	time for administration	on and no parameters.				<b>\</b>
	Review of the April 2	2018 eMAR for Resident #5				
	revealed:					
	-There was an entry	to check and record blood ast and dinner at 7:30 am and	·			
	4:30 pm.	15t and diffice at 1.55 am and	i l			
		d sugar ranged from 90 to				}
		in the "pm (as needed)"				
	section of the eMAR	t for Novolog insulin inject 3				
	times a day before n	neal(s) as directed, per SSI,				
		g 02/12/18 with no scheduled				
	time for administration	on and no parameters.		,		. [
	Review of Resident	#5's progress notes revealed	1			
	there was no docum	entation of the prescribing	<b>,</b>			1
	physician (Resident	#5's Endocrinologist) being				
	contacted to reques	t clarification of orders for SSI ninistering Novolog insulin as			•	
	SSI).	minioting Horolog mount de				
	L. handaw on 05/004	/18 at 10:30 am with Resident				
	#5 revealed:	110 at 10.30 am With Resident				
		ived insulin one time a day for		·	<del></del>	

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 05/03/2018 HAL080013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1915 MOORESVILLE ROAD CARILLON ASSISTED LIVING OF SALISBURY SALISBURY, NC 28147 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) D 344 Continued From page 26 D 344 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 -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

PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  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	
MAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1916 MOORESVILLE ROAD SALISBURY, NC 28147  (X4) ID PREFIX TAG  CAN ILLON ASSISTED LIVING OF SALISBURY  SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)  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	18
NAME OF PROVIDER OR SUPPLIER  CARILLON ASSISTED LIVING OF SALISBURY  SALISBURY, NC 28147  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 silding 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	18
NAME OF PROVIDER OR SUPPLIER  CARILLON ASSISTED LIVING OF SALISBURY  SALISBURY, NC 28147  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  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	18
CARILLON ASSISTED LIVING OF SALISBURY  1916 MOORESVILLE ROAD SALISBURY, NC 28147  CAN ID PREFIX TAG  CAN ID PREFIX TAG  CONTINUED FROM INSTANCE IDENTIFYING INFORMATION)  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 silding 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	
CARILLON ASSISTED LIVING OF SALISBURY  1916 MOORESVILLE ROAD SALISBURY, NC 28147  CAN ID PREFIX TAG  CAN ID PREFIX TAG  CONTINUED FROM INSTANCE IDENTIFYING INFORMATION)  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 silding 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	
CARILLON ASSISTED LIVING OF SALISBURY  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	1
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physicianThe facility policy was to notify a resident's	
-The facility policy was to notify a resident's	
-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.	
Latanian on 05/02/49 at 4:20 pm with the regional	
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.	

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 05/03/2018 HALOBG013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1915 MOORESVILLE ROAD CARILLON ASSISTED LIVING OF SALISBURY SALISBURY, NC 28147 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 344 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 avaliable 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.

Division of	Health Service Regu	lation			(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	COMPLETED
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	AN ADED ON OUROUICE	STREET ADD	RESS, CITY, STAT	E, ZIP CODE	
NAME OF PR	OVIDER OR SUPPLIER		RESVILLE ROA		
CARILLON	ASSISTED LIVING OF	eat repliev	Y, NC 28147	-	
			<del>.                                      </del>	PROVIDER'S PLAN OF CORRECTION	N (X5)
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PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIAIE
,,,,,			<b></b> _	DEFICIENCY,	
D 344	Continued From page	- 79	D 344		1.
ט אייי	•		1 }		12-17-18
	-It was her understan	iding that the Endocrinologist	! ]		Ψ.,,ι
	knew the facility did i	not administer routine sliding	1		🔌
	scale insulin and was	s only receiving stat doses of			ch-apaho
	SSI Novolog occasio	nally for FSBS over 350.	1		4 1-4011 15
	Interview on 05/03/18	e at 4:20 pm with the	1		( )  -
	Executive Director (E	EU/ Lovesjey.	\		
	Sho did not know Re	esident #5 had an order for	1		
	O hatch ISS polyoge	2/22/18 that needed to be	1		1
1	clarified for use only	when blood sugars were	1		
	greater than 350 and	the on-call prescribers were	1 !		
	contacted per facility		1		
	-The assisted living I	RCC was responsible to			
	assure all medication	n orders were clear before		D402	
	appearing on the eM	IAR.	1	D482	, }
	-The ED would work	with the regional RN to	1	10A NCAC 13F .1501(a) Use	i I
	assure Resident #5':	s Novolog insulin order was		Physical Restraints and Alter	natives
	clarified.		Ì	,	
}			D 480	The facility has not and will 1	not use
D 482	10A NCAC 13F .150	)1(a) Use Of Physical	D 482	•	
	Restraints And Alter	nativ <del>e</del> s	ì	physical restraint or any alter	
				equipment for physical restra	aint under
		01Use Of Physical Restraints	1	any circumstances.	1 1
	And Alternatives	ome shall assure that a	1	·	
1	(a) An adult care no	ny physical or mechanical	1	On 5/4/2018 all residents wit	h hed
1	dovice attached to c	or adjacent to the resident's			
	body that the reside	nt cannot remove easily and		rails were evaluated for abilit	' 1 1
Ì	which restricts freed	om of movement or normal		reposition using bed rails. Pl	hysician
	access to one's bod		-	orders for residents with con	tinued
	(1) used only in thos	se circumstances in which the	1	need for bed rails are located	
	resident has medica	al symptoms that warrant the	1		l l
	use of restraints and	d not for discipline or		respective resident files, nurs	
]	convenience purpos	ses;		evaluation is noted in resider	
1	(2) used only with a	written order from a physician	1	and PT evaluation orders ha	ve been
	except in emergence	ies, according to Paragraph	1	requested as additional overs	
	(e) of this Rule;	Single-section that would		/ /	
		ive restraint that would	1		
	provide safety;		<u> </u>		

	f Health Service Regu of DEFICIENCIES	(X1) PROVIDER/SUPPLIER/GLIA		CONSTRUCTION	(X3) DATE SU COMPLE	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			}
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NAME OF DE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1916 MOC	RESVILLE RO	AD .		ļ
CARILLO	NASSISTED LIVING OF	SALISBURY SALISBUI	RY, NC 28147			
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	safety to the resident decline in the resident tried and documente (5) used only after an planning process have mergencies, accord Rule; (6) applied correctly manufacturer's instruorder; and (7) used in conjunctive effort to reduce restruction to reduce restruction to reduce restruction to reduce the resident from volu opposed to enhancive while in bed. Example are: providing restouch abilities to stand safe device that monitors bed, placing the bed frequent staff monite in tolleting and amb providing activities, environment with medical places.	ternatives that would provide it and prevent a potential nt's functioning have been d in the resident's record. In assessment and care is been completed, except in fing to Paragraph (d) of this according to the actions and the physician's	D 482	staff in-servicing regarding restraints versus assistive/ repositioning devices was ini on 5/4/2018 and is ongoing. Responsible parties have been notified and are documented consent for use of bed rails. new orders for bed rails will MD order, PT evaluation and documented family consent.  The facility will ensure that a physical or mechanical equiputilized to assist a resident for positioning or mobility purpefforts to help resident reduced decline in functioning and in opportunity for the residence independence are only utilizunder the following circums 1) the resident has a medical	n l Any require d uny oment or ooses, ce mprove e's ed tances	6-17-18 0n-gain
	cushions.  This Rule is not me TYPE B VIOLATIO			condition or symptoms that warrant the use of physical of mechanical equipment and absolutely never be utilized a restraint or for punitive purples only in accordance were strainted and the straint or for punitive purples.	or would as a poses	
	reviews, the facility restraints were use and care planning through a team pro	ions, interviews, and record failed to assure physical donly after an assessment process had been completed cess and used only with a a physician for 3 of 3 sampled		physicians order 3) provides the least restrictial alternative possible which sua residents need	ive	

STATEMENT	on of Health Service Regulation  MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SU COMPLE	
		10080JAH	B. WING		05/03	3/2018
_			DORESS, CITY, STA	OTF ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		ORESVILLE RO			
CARILLO	N ASSISTED LIVING OF	SALISBURY SALISBU	JRY, NC 28147		N	(X5)
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D 482	residents (#1, #6, and #7) residing In the Special Care Unit (SCU) who had full bilateral bed rails		D 482	4) used in to prevent potential decline in the residents cond and allow support in mainten	itioning	1
	(#7), ½ rails (#1), and	i nag full bilateral oed rails 1 ¼ rails (#6).		the residents independence 5) used only after an assessm	ent and	6-11-1
·	03/01/18 revealed: -Diagnoses included -She was intermitten -The section for restr -The recommended unitThere was an order protection due to fall -There was an order when in bed or chair	tly disoriented. aints was blank. level of care was secured for hipsters at all times for s. for a pull alarm at all times		care planning has been comp 6) the supportive equipment according to manufacturer's instruction and compliance of physician's orders 7)Used in conjunction with alternatives which provide so in the resident's ability, independence, mobility or positioning and do not inclu restraint of any kind.	is used with upport	on-opt
	resident was admitted Observation of Reside. 8:30 am revealed: -The resident was ly -The resident's bed window and had bilate. Both bed rails were Observation of ResideThe resident was note that the bed rail next to positionThe bed rail on the the down position. Review of a ResideThere was a physical	ded to the facility 02/23/2015.  dent #7's room on 05/03/18 at ing in her bed.  was located toward the ateral full length rails.  in the up position.  dent #7's room on 05/03/18 at		The Resident Care Director, Executive Director or other of Carillon representative will wany order for adaptive, physimechanical equipment to insuch supports as bed rails upreceipt of the order.  The Resident Care Director Resident Care Coordinator, Executive Director will physinspect all equipment upon implementation to ensure the no component of restraint.	qualified verify ical or clude con	

Division o	<u>f Health Service Regu</u>	lation	Large Lind Tips E	CONSTRUCTION	(X3) DATE SU	IRVEY	
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CARILLO	N ASSISTED LIVING OF	SALISBURY SALISBUI	RY, NC 28147		<del></del> 7	Wet.	
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		- 22	D 482			}	
D 482	1.		"	The Executive Director, Res	sident	1 ~ .	
	-There was no physi	cian's order for full length bed		Care Director or other qual		677-18	
	rails available for rev	riew. cal restraint consent form or	ነ	Carillon representative will		\$	
	documentation for al	ternative to restraint	ļ	an monthly audit of all med		13. m.	_1
	assessment available	e for review.	1	or adaptive equipment orde		M-ddw	1
	<b>h</b>		1		rea m	<b>()</b>	ب
i i	Review of Resident	#7's current assessment and	- [	support of the	المستندسية		
	1	gned and dated 09/01/17		residents' needs to ensure c		1	
	revealed:	lert, verbal, and oriented to		and on-going compliance.		1 [	
	self			evaluation of a resident's co			
	-The resident requir	ed extensive assistance with	1	and need for mechanical or			
	transferring, and am	bulation/locomotion.		equipment will be complete	ed on a	}	
]	-The resident was to	otally dependent with ng, tolleting, dressing and	Ì	quarterly basis to ensure co	ntinuity	1	
ļ	grooming.	ng, tonoung are said and	1	of care and proper adjustm	ents to	1	
	-The resident had n	o physical restraint		the resident's service plan a		1	
	documented on the	care plan.		implemented accordingly.		1	
Ι.	Review of Resident	#7's Licensed Health				}	
	Professional Suppo	rt (LHPS) review dated	ŀ	The Executive Director, Re	gional	1	
	02/07/18 revealed:			Operations Director, Region	_		
1	-The marked LHPS	tasks were ambulation with		Nurse or other qualified Ca		1	
	assistive device (Wi	neelchair), inhalation of ulizer, application and removal		representative will conduct	monthly	,	
	of glasses, and tran	nsferring semi or		audits of resident clinical r	acorde to	Ţ	
]	non-ambulatory res	sidents.					
1	-The resident was I	noted to be alert to self and		ensure compliance with th	IS	1	
1	general surrounding	gs, and mobile via wheelchair		requirement.		1	
1	with staff assistThe resident was	seen by Hospice.				1	
	-No recent falls we	re noted this quarter.				1	
1	-Hipsters were to b	e in place at all times and pull		}			
	alarm in place at a	I times.					
	-There was no doo	umentation for bed rails.				1	
	Telephone intervie	w on 05/03/18 at 12:40 pm with	i			1 1	
	Resident #7's Pow	er of Attorney (POA) revealed:				1	
1	-Resident #7 resid	ed at the facility for 3 years.				_ {	
1	I Decident #7 had t	he hospital bed with full bed	I				

Division of	<u>f Health Service Regu</u>	lation	(X2) MULTIPLE CO	DISTRUCTION		E SURVEY	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
AND PLAN O	F CORRECTION	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	A, BOILDING.		1	ļ	
		НА <u>L</u> 080613	B. WING		0	5/03/2018	
· ·				215 AODE		ļ	
NAME OF PE	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			1	
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CARILLON	I ASSISTED LIVING OF	SALISBURT SALISB	URY, NC 28147		PRECTON	(X5)	l
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D 482	Continued From pag	e 33	D 482				l
			- 1			1.	ı
	rails since she came	ourchased a scoop mattress	1 !			1 171	0
	- I ne POA nao also p	shortly after arriving at the	1 1			10111	8
	to help blevery land	on 05/03/18 revealed a	}			<b>       </b>	1
	scoop shaped matter	ess on Resident #7's bed).				יים מע	ما
	-"Resident #7's last	fall from the bed was				DA F. AO	Ţ١
	09/06/16; the bed ra	ils help keep her from falling	]				L
	out of bed."	ı					Γ
Ì	-She did not remem	ber signing a consent for bed	-   -			İ	1
<b>\</b>	rails but she would s	sign forms if the facility	1 1				l
1	requested; she wan	ted rails or anything that	i .				1
	would protect the re	sident from failing.	- [ 1			1	١
		ervices for a long time, but	<u>.</u>			1	ı
İ	may not now.	etting a new bed soon,					1
1	-Resident #1 was y	cility, since the resident was no	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				1
	longer had Hospice	services.					l
	Interview on 05/03/	18 at 3:35 pm with two					
1	personal care aides	(PCA) in the special care unit				ļ	1
Į.	revealed:		1			1	1
	-The PCAs were tra	ained by a former Resident	1				
	Care Coordinator a	and former PCAs.				-	
	They put the bed r	alls up for Resident #7	<b> </b>			1	1
	whenever she was	in the bed to help prevent her					1
	from falling out of the	ne seu. when the last time Resident					Н
	#7 had fallen out of	f bed.		}			ł
	1	/18 at 3:40 pm with a third PCA	.				
	revealed:	To at othe pict and a diversion					1
1	She was trained h	y PCAs to put the bed rails up					١
1	on Resident #7 wh	enever she was in the bed.					I
	-She had worked a	at the facility for longer than					-
	Resident #7 had b	een at the facility and had		1			
	always raised her	rail up when she was in the					Į
	bed.						1
		vio it too im with a vocional					1
	Interview on 05/03 operations directo	3/18 at 4:00 pm with a regional revealed:					┙

Division o	Health Service Regu	ation(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D MARKET		05/03/2018
		HAL080013	B, WNG		1 OSIGOIZOTO
NAME OF PR	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT		
	N ASSISTED LIVING OF		OORESVILLE ROA	/D	
CARILLO			URY, NC 28147	PROVIDER'S PLAN OF CORRECT	ON (X5)
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLEIS
D 482	Continued From pag	ө 34	D 482		
	-He came to the facil	ity, along with other regional			1 ~
	representatives to pe	erform random corporate			10-11-14
	audits and reviews.	t of the corporation and was			4
	supposed to be resti	raint free.			on push
ļ	"Resident #7 had a )	new bed ordered on 04/20/18			by-obih
	and the order includ	ed ¼ rails for repositioning.	Į.		
	The bed was ordere	d and delivered today. ave had full bed rails on the	1		
ļ	bed ordered by Hos	pice and they were		-	
I	overlooked.	•		1	
Į.		on 100 40 at 2:00 am with the			
	Refer to interview of regional Registered	n 05/03/18 at 3:00 pm with the		1	
	-				
	Refer to interview o Executive Director.	n 05/03/18 at 4:00 pm with the			
	2. Review of Resid	ent #6's current FL2 dated			
	-Diagnoses include	d unspecified dementia	ļ		
· l	Alzheimer's.		1		
ļ	-She was constanti -The section for res	y disoriented. Arcintowas blank			
	-The recommended	traints was blank. I level of care was secured			
	Unit.		Ì		
	-There was an orde	er for hipsters at all times.	1		
		er for a bed pull alarm at	ſ		
1	bedtime.			•	
	Review of Residen	t #6's Resident Register	Ì		1
	revealed the reside	ent was admitted to the facility			
	on 10/10/2013.				
	Observation of Re	sident #6's room on 05/03/18 at			\ \ \
1	3:35 pm revealed:	dressed and lying on her bed	1		
	in the room.				·
	-The resident's be- wall and had bilate	d was located toward the side eral ½ rails.			

Division o	f <u>Health Service Regu</u>	lation		NUTTONICTION	(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	Mortingeneri	COMPLETED
AND PLAN C	F CORRECTION	WEBIT WHIST INDINE	A. BUILDING:		
			B. WNG		05/03/2018
		HAL080013	D. WING		00,00.2515
NAME OF D	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	
		1915 MG	OORESVILLE ROAL	)	
CARILLOI	N ASSISTED LIVING OF	SALISBURY SALISB	URY, NC 28147		
	SUMMARYS	TATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD)	(X5) RE COMPLETE
(X4) ID PREFIX	ÆACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
TAG	REGULATORY OR 	LSC IDENTIFYING INFORMATION)	, no	DEFICIENCY)	
	<u> </u>		2.400		
D 482	Continued From pag	e 35	D 482		
	   _The hed rail next to	the wall and on the other	1		21-1-1
	side of the bed were	in the up position.	1 1		6-17-40
l					<u> </u>
	Review of a Resider	t #6's record revealed:			TE ON h
	-There was no physi	ician's order for ¼ length bed	l l		(M)-4011
	rails available for rev	view.			
,	There was no physi	ical restraint consent form or	-		
		Iternative to restraint	-   -		
	assessment				1
	Dovious of Resident	#6's care plan signed and	i i	•	
1	dated 03/07/18 reve	aled:			
	-The resident was o	riented to self.	1		
1	-The resident regula	ed limited assistance with	- <b>l</b> - l		
1	transferring.		-   }		
	-The resident requir	ed extensive assistance with	ì		
	ambulation/locomot	ion, and grooming.			
1	-The resident was to	otally dependent with	1		
	assistance for Datri	ng, toileting, and dressing. ipsters and chair alarm			Ì .
1	documented.	ilpatera and unan ulaim			1
	-The resident had r	o physical restraint		·	
Į	documented on the	care plan.			}
ļ.					
1	Review of Residen	#6's Licensed Health	]		
	Professional Suppo	ort (LHPS) review dated			ļ
	03/14/18 revealed:	Analys ware embrication with			
1	-The marked LHPS	tasks were ambulation with	}		
	assistive device (w	heelchair and walker), noval of glasses, physical		·	
	application and ren	erring semi or non-ambulatory			}
1	residents.	Ottoria contra de trons anno accesso.			1
	-The resident was	noted to be alert to self only,	Ì		
1	and ambulates via	wheelchair.			
-	-A fall on 1/11/18 v	vas noted this quarter.			
,	-There was no doo	sumentation for bed rails.			
	Telephone intervie	w on 05/03/18 at 12:40 pm with		}	
	Resident #6's Pow	ver of Attorney (POA) revealed: been a resident at the facility for	.		
1	I -Resident#6 had l	Deen a resident at the lacinty for	l	<u> </u>	

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Division of	<u>f Health Service Regu</u>	lation	000 N - 2101 F 0	OMETRICTION	(X3) DATE :	SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	UNSTRUCTION	COMPL	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			Ì
		l	1		1	1
		HAL080013	B, WING		05/	03/2018
_,			<del></del>			
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STATE			
		1915 MOC	ORESVILLE ROAD	•		1
CARILLON	ASSISTED LIVING OF	SALISBURY SALISBU	RY, NC 28147			<del></del>
<del></del>	CULTUADY ST	TATEMENT OF DEFICIENCIES	ID I	PROVIDER'S PLAN OF CO	RRECTION	(X5) COMPLETE
(X4) ID PREFIX	ÆACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE APPROPRIATE	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	(A) ( NO) ( Will	1 1
			<del></del>			-
D 402	Continued From pag	e 36	D 482			1 354
D 482	Continued From pag	-	i			1V-17-18
1	many years (since 20	013).				M 51.14
. '	-Resident #6 has had	d the bed rails "for a few	1 1			3
	years".		1		(	イベーいり入り
<b>[</b>	-Originally, the bed r	ails heip to keep her from	1		•	שוי טף־יונף
'	falling out of bed.		1 1			], ] [-
	-The resident could s	stand and pivot from wheel	Į l			
	chair to bed and wou	ıld need the rail for				<b> </b>
1	assistance.		1 1			
	-She did not rememi	ber signing a consent for bed	<b>!</b>			1 .
	rails but she would s	sign forms if the facility	-		•	1
	requested.					}
Ĭ.	1 Codassoca.		]			
	Interview on 05/03/1	8 at 3:35 pm with two	1			1
	nersonal care aides	(PCA) in the SCU revealed:				1
	The PCAs were tra	ined by a former Resident	1 }			
1	Care Coordinator (8	(CC) and former PCAs.	1 1			\ \ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
l .	They put the hed ra	ails up for Resident #6				
1	who nover the was I	n the bed to help prevent her				
1	from falling out of th	e hed	- I			·
l	Maithor DCA know	when was the last time	1			1.
	Resident #6 had fall	lon out of had	- \			
1	Resident #6 had rai	lett out or bed.	i l		ē	1 1
	T-lembana intendeu	on 05/04/18 at 1:15 pm with	1			
!	Telephone interview	cian's office nurse revealed				
	Resident #o's hilysi	nentation for the facility				1
1	there was no docum	rentation for the racinty	1			1 1
	contacting the phys	ician's office for an order for				ì
. 1	bed rails for Reside	nt #1, or any documentation				}
1	of an assessment to	or bed rails for the resident.				<b> </b>
1	25/25/	40 -1 2:40 nm with a third DCA		-	-	<b> </b>
	Interview on 05/03/	18 at 3:40 pm with a third PCA				1 1
	revealed she was ti	rained by a former RCC and	[	<b>(</b>		1 1
1	former PCAs to put	the bed rails up on Resident				1
	#6 whenever she w	as in the bea.				
		05/00/40 -1 0.00 with the	Ì			1
1	Refer to interview of	on 05/03/18 at 3:00 pm with the		1		-   -
1	regional Registered	1 Nurse (KN).		\		
1		and the state of the state of		1		
1		on 05/03/18 at 4:00 pm with the				
1	Executive Director.		1			
1	1					

<u>Division o</u>	<u>if Health Service Regu</u>		<del></del>		(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '	CONSTRUCTION	COMPLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		1
					]
		1151 000042	B. WING		05/03/2018
		HAL080013			
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DORESS, CITY, STAT	E, ZIP CODE	
		1915 MO	ORESVILLE ROA	ND	
CARILLO	NASSISTED LIVING OF	SALISBURY SALISBU	JRY, NC 28147		1
				PROVIDER'S PLAN OF CORRECTION	ON (X5)
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE
PREFIX	(EACH DEFICIENC	LSC (DENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	PRIATE DATE
TAG	110000		1	DEFIGIENCY)	
-			77.100		1 500 1 10
D 482	Continued From pag	e 37	D 482		6-17-18
	2 Douisuu of Pecide	ent #1's current FL2 dated	1 1		ا ئ
	07/11/17 revealed:	MAN S CONTON I EL CAUSA	1 .		المريح أثرا
		dementia with behavioral			<i>\</i> 0∩-40\r
l		delie ind with bottom of		•	1 6 1
	disturbanceShe was constantly	disoriented			~ 1
1	-She was constantly -The section for rest	rainte van blank	- i - I		
1	-I UG 2000001 101 1630	level of care was secured	-		
		level of care was secured	1	•	
	unit.		}		·
	D 4 D 1-1-2-1-1	Hale Decident Decistor			
	Review of Resident	#1's Resident Register			
		nt was admitted to the facility			1
1	on 07/27/16.				
	Ot and the of Book	dent #1's room on 05/01/18 at	i '		l
		delit#13 idolii on bao a to at			
	10:32 am revealed:	at in the room			} <b>[</b>
ĺ	-The resident was no	was pushed against the wall		Į.	
			ļ		l
1	and had bilateral 1/4		į		
	· ·	the wall was in an up			
	position.	all an aide of the bad was in	_		
		other side of the bed was in			
	the down position.			[	1
	ol " -f Desi	ident #41e room on 05/03/18 at			
i i		ident #1's room on 05/03/18 at			
1	8;30 am revealed:	the well was in an up			i
		the wall was in an up		,	
1	position.	the second and upo in		1	i i
		other side of the bed was in	l l		
	the up position.	_			
1		-1 #41- uppord roughted:			
1	Review of a Reside	nt #1's record revealed:	1		
1	-There was a physic	clan's order dated 07/26/16 for		}	
		, semi-electric bed, and			
	wheelchair.				
}		sician's order for bed rails			
1	available for review		1	· ,	]
1	-There was no phys	sical restraint consent form or			1
1		alternative to restraint		1	
	assessment.		1	,	
1	1				

STATE FORM

STATEMENT	f Health Service Regu or DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SUF	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		HAL080013	B. WING		05/03/	2018
NAME OF P	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STATE	, ZIP CODE		
		1915	MOORESVILLE ROAD	o		
CARILLO	N ASSISTED LIVING OF	SALISBURY SALIS	SBURY, NC 28147		<del>-                                    </del>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 482	Continued From page	e 38	D 482	· · · · · · · · · · · · · · · · · · ·	1	1-17-12
	Review of Resident #	#1's assessment and care				0,110
	plan signed and date	d 09/01/17 revealed:	1 1		1	<del>\$</del>
	-The resident was ale	ert, verbal, and oriented to			<b>h</b>	a malan
	person and family me	embers.			Ψ	מאוטאבו ו
	-The resident require	ed extensive assistance with	}			
	each task of batring, ambulation/locomotic	toileting, transferring and				
	ampulation viocomotic	ed limited assistance with			ļ	Ì
	grooming.	A miles apple to the second			ł	
i	-The resident had no	physical restraint				
	documented on the o	care plan.				i
	Review of Resident	#1's I Icensed Health				1
		t (LHPS) review dated	1			
	03/14/18 revealed:					i
	-The marked LHPS t	asks were ambulation with		•		
		eel chair), and transferring			,	
	semi or non-ambulat	iory residents.				ļ
	to general surrounding	oted to be alert and oriented				
	wheelchair with staff	assist to propel.				
		ntation a pillow was used on				i
ł	rhe resident's left sid	le to keep the resident				
	upright.	•				
	-No recent falls were		l i			
	-There was no docui	mentation for bed rails.			ľ	l
•	   Telephone interview	on 05/03/18 at 3:08 pm with			İ	
ļ	Resident #1's Power	r of Attorney (POA) revealed;			-	
	-Resident #1 came t	o the facility with an order for		•	ļ	•
	a hospital bed, a spe	ecial mattress, and her				
1	wheelchair.					
		to help keep Resident #1				ı
	from falling out of the	e bed. igning a consent for bed rails				ļ
	but she would sign f	forms if the facility requested.	}			
	-She thought she re	membered giving verbal	}			
	consent for Residen	it #1 to have ralls on her bed.		i		
	Interview on 05/03/1	18 at 3:35 pm with two				

Division o	f <u>Health Service Regu</u>	lation		OLICITALISTICAL	(X3) DATI	E SURVEY	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			PLETED	
AND PLAN C	FCORRECTION		A. BOLDING!			ļ	
		   HAL080013	B. WING		0:	5/03/2018	
				7D CODE			
NAME OF PI	ROVIDER OR SUPPLIER		DORESS, CITY, STATE				1
CARILLO	N ASSISTED LIVING OF		IORESVILLE ROA! URY, NC 28147	IJ			
OANIEEO!			<del></del>	PROVIDER'S PLAN OF COL	RRECTION	(X5)	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE APPROPRIATE	COMPLETE	
		- 20	D 482			,	ļ
D 482	Continued From pag		-			11-17-	10
	personal care aides	(PCA) in the SCU revealed:	-   -				1,0
	-The PCAs were trail	ned by a former Resident	- i - 1			2002	41
	Care Coordinator an	io for Posident #1	1 1			The Control	<b>1</b> 0"
ı	-They put the bed ra	n the bed to help prevent her	1 }				ľ
	from falling out of the	a had.	- { -			1	į .
	-Neither PCA knew I	the last time Resident #1 had	<b>!</b>				
	fallen out of bed.		-			<b>,</b>	
	,						1
		8 at 3:40 pm with a third PCA					
	revealed:	r DOC and former	1				1
Ì		a former RCC and former	1				
	PCAs.	the facility for longer than					
	Posident #1 had he	en at the facility and had				1.	1
1	always raised her be	ed rall up when she was in the				,	1
	bed.	•					
	Tolophone intentiew	on 05/04/18 at 1:15 pm with					
1	Resident #1's physi	cian's office nurse revealed		,		ļ	
	there was no docum	nentation for the facility					
ł	contacting the phys	ician's office for an order for	Ì			l l	
ļ	bed rails for Reside	nt #1, or any documentation	1		•		1
]	of an assessment f	or bed rails for the resident.					ı
	Defents intonious	on 05/03/18 at 3:00 pm with the	ļ			1	1
	regional Registered	Nurse (RN).					1
		on 05/03/18 at 4:00 pm with the					- 1
	Executive Director	•				ļ ,	1
	Interview on 05/03/	/18 at 3:00 pm with the regional	]				
	Registered Nurse (	RN) revealed:				1	-
	-The regional RN h	ad not addressed bed rails at					1
	the facility previous	sly.	1				1
	-All corporate facili	ties, including this facility, were	<b>.</b> .				
	supposed to be res	straint free.					
'	-Usually, the facility	y would have physical therapy sision for a resident to have a				ļ	- }
		SISION OF A RESIDENT TO HAVE A	1				
1	bed rail						

Division o	f Health Service Regu	lation			THE PART OF THE PA
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE Co	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		
		HAL080013	B. WNG		05/03/2018
	<del></del>			ZID CODE	
NAME OF PR	ROVIDER OR SUPPLIER		ODDRESS, CITY, STATE		
	ASSISTED LIVING OF	CALICATION	ORESVILLE ROAL	0	
CARILLOR		SALISB	URY, NG 28147		- Ars
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	(X5) F COMPLETE
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	ATE DATE
TAG	REGULATORY OR	ESC IDENTIL HING IN CHIMATION		DEFICIENCY)	
			_		
D 482	Continued From page	e 40	D 482		l l.
	The facility should a	et an order for a bed rail, and	1 (		1212 R
	concept if it was not	in place because of a fall	-   -		417 (0)
	prevention.	an place section of a section			la l
	Any resident with he	ed rails should have originally	- }		<del>}</del>
	bod on order for 1/2 to	½ rails for mobility only.			NO 100 0
	The recidents' recor	rds had been thinned and	1 1	•	10x 1-40th 1
	orders for hed rails for	or most of the residents were			
	not available for revi		1		
	-She would ensure t	he primary care physician for	- [		
	all residents with a s	ide rail was contacted for the	· I		
	need for the rail were	e assessed, an order for bed	- 1		
-	rails obtained, conse	ent forms signed, and			
	documentation was	available for review.	- 1	•	
	Interview on 05/03/1	8 at 4:00 pm with the	-   -	•	
	Executive Director re	evealed:			
1	-The facility was sup	posed to be restraint free.	1		ì
		er short rails (1/4) to be a			
	restraint.		1		
	-The residents show	ild have a physician's order			
		sed for mobility where			
	present.	wile may have been thinned			
ì	- The orders for Ded	rails may have been thinned			
	not be located for re	records, but the orders could			ļ [
	not be located for re	eview. ure all residents with side rails			1
	-one would make st	ppropriateness of the rail and			
1	all paperwork (order	r, consent, and assessments)			
	all paperwork (order	he rail would be removed.			
	was completed of the				
1	The facility failed to	assure physical restraints	-		· ] ]
	were used only after	er an assessment and care			
	planning process ha	ad been completed through a			
	team process and t	used only with a written order		1	
	from a physician for	r 3 of 3 sampled residents (#1,			
1	#6, and #7) who ha	id full bilateral bed rails (#7), 1/2			·
1	rails (#1), and 1/4 rai	ils (#6) which was detrimental	*		
1	to the health, safety	y and welfare of the residents			1
	and constitutes a T	ype B. Violation.			
1				<u> </u>	

Division of	Health Service Regu	lation			(X3) DATE SU	RVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	COMPTE,	
AND PLAN O	FCORRECTION	DENTIFICACION NOMBER.	A. BUILDING: _			
						10040
	,	HAL080013	B. WNG		06/03	/2018
		STOCET AN	DRESS, CITY, STA	ATE, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER					
CARILLON	ASSISTED LIVING OF	CALICHIEV	RESVILLE RO	AD		
			RY, NC 28147	DROUGHERS BLANCE CORRECTION		(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE ]	COMPLETE , DATE
İ						
D 482	Continued From page		D 482			, ,
0 402				D914 G.S. 131D-214-21(4)	]:	h-M-i R
	VIOLATION SHALL	DATE FOR THE TYPE B NOT EXCEED JUNE 17,		Declaration of Resident Rights	3	3,114
	2018.			The Facility has and will always ensu	ire all	- ליטו
			D914	residents are free from mental and p	hyeical	o ryok
D914		claration of Residents' Rights	D914	abuse, neglect and exploitation.	ilysical	
	G.S. 131D-21 Decla	ration of Residents' Rights			}	ì
	Every resident shall	have the following rights:		The facility has not and will not use	physical	
	4. To be free of ment	lal and physical abuse,		restraint or any alternative equipmen	nt for	- 1
	neglect, and exploita	ition.	}	physical restraint under any circums	stances.	· •
		and began				•
	This Rule is not met	as evidenced by: ins, interviews, and record		The facility will ensure that any phys		,
]	Based on observation	ailed to assure residents		mechanical equipment utilized to as	sist a	
	were free of nealect	and exploitation as related to		resident for positioning or mobility		`
	the use of physical re	estraints and alternatives.	1	purposes, efforts to help resident rec	luce	<b>'</b>
	GIO GOO EI PITATO		- [	decline in functioning and improve		
	The findings are:			opportunity for the residence's independence are only utilized unde	ar the	
1	D d been satis	ons, interviews, and record	1	1 -	n the	
	Based on observant	ailed to assure physical		following circumstances		i
	rectraints were used	only after an assessment		1)the resident has a medical condition		1
	and care planning p	rocess had been completed	1	symptoms that warrant the use of pl	nysical or	} <b>i</b>
}	through a team proc	ess and used only with a		mechanical equipment and would a	bsolutely	1 1
	written order from a	physician for 3 of 3 sampled		never be utilized as a restraint or for	punitive	1 1
	residents (#1, #6, ar	rd #7) residing In the Special		purposes		1 1
	Care Unit (SCU) wh	o had full bilateral bed rails		2)used only in accordance with a ph	ıysicians	1 1
1	(#7), ½ ralls (#1), an	nd 1/4 rails (#6). [Refer to Tag	1	order		1 1
	D 0482, 10A NCAC	13F .1501(a) Use of Physical		3)provides the least restrictive altern	native	1
1	Restraints and Alter	natives (Type B Violation).]		possible which supports a residents		
			D935	4)used in to prevent potential declir		<b> </b>
D935	G.S.§ 131D-4.5B(b)	ACH Medication Aldes;	D935	residents conditioning and allow su		) [
1	Training and Compe	etency		maintenance of the residents indepe		
1 .	0 0 8 404D 4 ED #	a) Adult Cara Home		5)used only after an assessment and	care	1
'	G.S. § 131D-4.5B (I	raining and Competency		planning has been completed		1
	Medication Aldes; I Evaluation Requirer	nents		6) the supportive equipment is used	l	1 /
1	Evaluation veduiter	nome.		according to manufacturer's instruc	ction and	1 · 1
1	(b) Beginning Octob	oer 1, 2013, an adult care		compliance with physician's orders		

_	STATEMENT	f Health Service Regu of DEFICIENCIES F CORRECTION	ation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURY		
			HAL080013	B. WING		05/03/2	2018	
-	NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST				
	CARILLO	ASSISTED LIVING OF	SALISBURY SALISBU	JRY, NC 28147		<u></u>	der)	
	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE	
	D935	home is prohibited from any unsupervised methat individual has promedication aide during an adult care home of the following:  (1) A five-hour training Department that including all of the following:  a. The key principles administration.  b. The federal Center Prevention guideline applicable, safe Inject procedures for monifoleeding occurs or the exists.  (2) A clinical skills exists.  (2) A clinical skills exists.  (3) Within 60 days from individual must have an additional 10-led developed by the Detraining and instruction.  2. The federal Center Prevention guideline applicable, safe inject procedures for monifoleeding occurs or the exists.  b. An examination of the Division of Herical Prevent	om allowing staff to perform edication aide duties unless eviously worked as a ang the previous 24 months in or successfully completed all ag program developed by the udes training and instruction of medication are for Disease Control and in son infection control and, if etion practices and toring or testing in which are potential for bleeding valuation consistent with 10A d 10A NCAC 13G .0503. On the date of hire, the completed the following: apartment that includes on in all of the following: so of medication control and if ers of Disease Control and in so on infection control and, if	10935	(Continunation) D914 G.S. 131D-2 Declaration of Resident Rights 7) Used in conjunction with alternate which provide support in the residuability, independence, mobility or and do not include restraint of any and do not include restraint of any and do not include restraint of any other qualified Carillon representative rify any order for adaptive, physical mechanical equipment to include such as bed rails upon  receipt of the order.  The Resident Care Director, Executive other qualified Carillon representative any order for adaptive, physical or me equipment to include such supports as upon receipt of the order.  The Resident Care Director, Resident Coordinator, Executive Director will pinspect all equipment upon implement ensure there is no component of restrative and monthly audit of all mechanical or equipment ordered in support of the need to ensure continued and on-goir compliance. An evaluation of a reside condition and need for mechanical or equipment will be completed on a quato ensure continuity of care and propadjustments to the resident's service pimplemented accordingly.  The Executive Director, Regional Ope Director, Regional Nurse or other quatorial or equipment end accordingly.  The Executive Director, Regional Ope Director, Regional Nurse or other quatorial or equipment end accordingly.	ctives ent's positioning kind.  Director ive will or supports  Director or will verify chanical bed rails  Care ohysically tation to oint.  Director or will conduct adaptive residents and aptive creations diffied monthly	2-17-18 n-goin	3
		This Rule is not me	t as evidenced by:		compnance with this requirement.			

STATEMENT	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	- CONGRESSION	(X3) DATE SURV COMPLETE	
•		HAL080013	B. WING		05/03/2	018
				TO TIP GOOK		
NAME OF P	ROVIDER OR SUPPLIER		ODRESS, CITY, STA			ŀ
CARILLO	N ASSISTED LIVING OF		ORESVILLE RO IRY, NG 28147			
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E   C	(X5) COMPLETÉ DATE
D935	Based on observation reviews, the facility for sampled medication administered medical Clinical Skills Comparing to administering.  The findings are:  Review of Staff D's parameters of staff D's parameters facility as a rather date at the current facility.  There was document Skills Checklist was sister facility.  There was no document Clinical Skills Checklist Checklist was sister facility.  Review of a Medical provided by the Exelit was completed on facility.  Review of Resident Review of Resident	ns, interviews, and record ailed to assure 1 of 3 aides (Staff D) who allons had a Medication elency checklist completed predications.  Dersonnel file revealed: I from a sister facility to the nedication aide (MA) with a ent facility of 03/26/18. Intation a Medication Clinical completed on 12/14/17 at the mentation a Medication clinical completed for the list was completed for the tion Clinical Skills Checklist cutive Director (ED) revealed 04/13/18 for the current	D935	D935 G.S. 131D-4.5B(b) Medication Aidd Training and Competency  Note: Carillon contends that the faddemonstrated substantial compliant this rule area. As identified in the sof deficiencies, the Medication Aid competency was validated as docur on the LHPS date 12/14/17 while we for Carillon Assisted Living in anot facility and further validated on 4/1 To further ensure compliance, the identified team member was re-val for skills competency by the Region on 5/4/2017.  The facility will ensure all Medicating Technicians administering medical have a Medication Skills Competer checklist is completed prior to the administration of medications.  The Resident Care Director and Expirector or other personnel will conveckly review and audit of the staff	cility nce in tatement e's mented vorking ther 13/2018. idated nal Nurse lion tions will ncy	0-17-1 in-90i
	March, and April 20 documented admini 02/27/18, 02/28/18, 03/14/18, 03/15/18, 03/22/18, 03/23/18, 04/02/18, 04/03/18, 04/10/18, 04/11/18,	stration of medication on 03/06/18, 03/07/18, 03/09/18, 03/16/18, 03/20/18, 03/21/18, 03/26/18, 03/26/18, 04/01/18, 04/05/18, 04/07/18, 04/09/18,		compliance tracker to ensure compthis requirement.  The Executive Director, Regional Operations Director, Regional Nurother qualified personnel will concadditional audit of personnel recommonthly to ensure further review a compliance with this requirement.	rse or duct an	·
	Interview with a Rea	sident Care Coordinator				

Division of Health Service Regulation  X(1) PROVIDERSUPPLIER/CLIA A BUILDING:  HALOBOOT3  RAME OF PROVIDER OR SUPPLIER  CARILLON ASSISTED LIVING OF SALISBURY  X(2) BURNEY  A BUILDING:  HALOBOOT3  B. WING  O5/03/2018  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1915 MOORESVILLE ROAD  SALISBURY, NC 28147  X(2) ID PREFIX TAG  X(3) ID PROVIDERS PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D935  Continued From page 44  -The Registered Nurse (RN) was responsible for ensuring the Medication Clinical Skills Checklist was supposed to be completed with orientation to the facility.  -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.
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1915 MOORESVILLE ROAD SALISBURY, NC 28147  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG CROSS-REPERENCED TO THE APPROPRIATE OATE  PREFIX TAG CROSS-REPERENCO TO THE APPROPRIATE DEFICIENCY)  D935 Continued From page 44  -The Registered Nurse (RN) was responsible for ensuring 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.
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CARILLON ASSISTED LIVING OF SALISBURY  1915 MOORESVILLE ROAD SALISBURY, NC 28147  (X4) ID PREFIX TAG  CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.
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SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION SHOULD BE   CROCH DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   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.
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Checklist checked off by the nurseStaff D transferred to the current facility from a sister facility.
-Staff D transferred to the current facility from a
sister facility.
sister facility.
Last OLEGIO transformed to the current tacility
-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
O5/03/18 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
facilityShe 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

	f Health Service Regu	lation	Atm AUGUSTOLE C	ONCYCLICTION	(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CI.IA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		COMPLETED
ANDPLANO	L CONTECTION		7. BOLDING.		•
		HALOBORI 12	B, WING		05/03/2018
		HAL080013		- NO CODE	1
NAME OF PE	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		
CARILLON	ASSISTED LIVING OF	1 10 D 1 1D 1/	OORESVILLE ROA' URY, NC 28147	D.	
ONNICEO.			<del></del>	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
	Continued From page	e 45	D935		10-148
1		- 10	1		6-1948 6 00-90194
	at the facilityNew staff shadowed	ther or the RCC and	1		0000
	completed the Medic	ation Clinical Skills Checklist	-   -		10x )-4014x
	after they administer	ed medication to residents.	-   -		0
	-if there were new st	aff transferring from a sister	- 1 {	•	
	facility to the current	facility, all records including cal Skills Checklist would	- 1 1		
	transfer.	al Skills Officialist House			
	-She did not know th	e Medication Clinical Skills	<b>i</b>		
	Checklist was neede	ed for Staff D at this facility.			
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