PRINTED: 01/30/2019 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPL	EIED
		HAL060153	B. WING		01/0	8/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CARILLOI	N ASSISTED LIVING OF	MINT HILL	GARET WALLA'S, NC 28105	ACE ROAD		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
		sure Section and the nent of Social Services survey on January 7-8,				
D 270	D 270 10A NCAC 13F .0901(b) Personal Care and Supervision		D 270			
	10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.					
	interviews, the facility according to the resid					
		ry of falls (Resident #3, #4,				
	1. Review of Residen 09/11/18 revealed: -Diagnoses included hypertension, mitral vhistory of fallsThe resident was ser	alve replacement and a				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL060153	B. WING		0	1/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STATE	E, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL	MARGARET WALLAC HEWS, NC 28105	CE ROAD		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 270	Continued From page 1		D 270			
	each prothrombin tin	ected by the physician after ne/international normalized d test used when taking a				
	revealed: -The resident was see of a wheelchairThe resident require ambulation, toileting grooming.	#3's care plan dated 07/03/18 emi-ambulatory with the use ed extensive assistance with bathing, dressing and ed limited assistance with				
	revealed: -A report dated 08/2: personal care aide (I #3 out of bed when I injuries notedA report dated 09/2: on 09/26/18, reveale the floor and his eye was left for the family-A report dated 11/12 fallA report dated 12/24 Resident #3 was four There was blood four head. The Emergence (EMS) was called an the ERA report dated 12/2.	2/18 at 2:15pm revealed a 4/18 at 9:15pm revealed nd on the floor in his room. nd on the left side of his by Management System and Resident #3 was taken to 7/18 at 5:40am revealed of the bed, there were no				
	Review of Resident reports revealed:	#3's Emergency Room (ER)				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		` ′	CONSTRUCTION	(X3) DATE	SURVEY
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		HAL060153		B. WING		01	/08/2019
NAME OF F	PROVIDER OR SUPPLIER	Ş	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL		GARET WALLA S, NC 28105	ACE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 270	and facial contusionAn ER visit dated 09 contusion to face, ski and head injuryAn ER visit dated 09 and eye injury with bl -An ER visit dated 12 head injury with a cor -An ER visit dated 12 head injury and knee Review of Resident # no documentation of Review of Resident # revealed: -On 09/07/18 occupa physical therapy (PT) living (ADLS) and tral -Resident #3 was see discharged on 10/18/ potential". Interview with a medi 01/07/19 at 3:25pm re -Resident #3 fell mos -Resident #3 required but really could not we -Resident #3 got out ambulate without ass -There were no intervals no fall mat, bed or supervisionThe standard checks 11:00pm to 7:00am al -There were no fall methe facility at all.	n tear to left side of face, n tear to left side of face, n/26/18 diagnosed with a food in the eye. 1/24/18 diagnosed with a focusion to the forehead. 1/26/18 diagnosed with a focusions. 1/26/18 diagnosed with a focusions of focusions of facts. 1/26/18 diagnosed with a focusion aide (MA) on evealed: 1/26/18 diagnosed with ambulational facts of	fall fall, fall, led fall. ok daily nax tion s to	D 270			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI		` ′	CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER	٠.	A. BUILDING:		COMP	LETED
		HAL060153		B. WING		01/	/08/2019
NAME OF F	PROVIDER OR SUPPLIER	S	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CABILLO	N ASSISTED LIVING OF	MINIT LIII I	601 MAR	SARET WALLA	ACE ROAD		
CARILLO	N ASSISTED LIVING OF	MINI FILL N	MATTHEW	S, NC 28105			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	reveled: -Resident #3 fell a lot issue because of his increased bleeding ris-Resident #3 falls mo morning while in his resident #3 "hit his resident #3 did not resident #3 fell a lot in the evening or earlesident #3 fell a lot in the evening or earlesident #3 could go required supervision resident #3 had 3-4 and she considered if Resident #3 was ser Room (ER) every tim Coumadin and the ble with itThere was no impler with Resident #3 such bed or chair alarms o	and she felt that was a becommadin and the sk. stly in the night or early oom. She was not sure whead every time". sed checks on Resident at every 2 hours during the tright. ecks during the day and as the Memory Care Unit have a fall mat, bed or change of the MCU. It is a superior of the falls were and most of the falls were and assistance. The head injuries with his fall at dangerous because commadin. The out to the Emergency is the eding tendencies that we mentation of interventions are as the use of a fall mat, increased supervision are every 2 hours during the every 2 hours during the	why. #3 air CA) The calculate is a continuous continuou	D 270			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER		l ` ´	CONSTRUCTION	· ,	E SURVEY PLETED
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		HAL060153		B. WING		01	/08/2019
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			5601 MAR	SARET WALLA	ACE ROAD		
CARILLO	N ASSISTED LIVING OF	MINT HILL	MATTHEWS	S, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page 4			D 270			
	member on 01/08/19 -She made a reques help/alternatives with -The ER physician re Manager in the ER to like Home Health, PT -The facility staff did in help/interventions to falls after speaking to September, 2018 about the staff to discuss anyth staff	t at the ER to receive so Resident #3. ferred her to the Case of help with other resour POT and Hospice. Into offer any type of help decrease or stop of help decrease or stop of the Administrator in out the falls with Resident at at the facility or being set up with the facility or being set up with the faciliting that might help Resident #3. To be and could not come see it would cause a brain bleed a conference with horns about the number of the risk of death because a brain bleed. Administrator a few day tho spice helping out. To the ER and in the ER and in the case a brain bleed. Administrator a few day tho spice helping out. To the ER and in the case a brain bleed. Administrator a few day tho spice helping out. To the ER and in the case a brain bleed. Administrator a few day tho spice helping out. To the ER and in the case a brain bleed. Administrator a few day tho spice helping out. To the ER and in the case a brain bleed. Administrator a few day tho spice helping out. To the ER and in the case a brain bleed. To the ER and in the ER and in the case a brain bleed. To the ER and in the ER and in the case a brain bleed. To the ER and in the ER and in the case a brain bleed. To the ER and in the ER and in the case a brain bleed. To the ER and in the ER and in the case a brain bleed. To the ER and in the ER and in the case a brain bleed. To the ER and in the Case and in the case a brain bleed. To the ER and in the Case and in the case a brain bleed. To the ER and in the Case and in the case a brain bleed. To the ER and in the Case and in the case a brain bleed. To the ER and in the case a brain bleed. To the ER and in the facility or being a brain bleed. To the ER and in the case a brain bleed. To the ER and in the facility or being a brain bleed. To the ER and in the facility or being a brain bleed. To the ER and in the facility or being a brain bleed. To the ER and in the facility or being a brain bleed.	some rces the ent d and ty sident felt 3. hing in a off of ain esident R. eer of falls use of is				

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STATE FORM 6899 MJQG11 If continuation sheet 5 of 44

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL060153	B. WING		01/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		5601 MAR	GARET WALL	ACE ROAD	
CARILLO	N ASSISTED LIVING OF	MINT HILL MATTHEV	/S, NC 28105		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 270	Continued From page	======================================	D 270		
	Resident #3.				
	Resident #5.				
	3:55pm revealed: -Resident #3 fell mos -Resident #3 was ser head primarily because risk of a "brain bleed" -She did not know what fall mat, bed or chat other than the normal day and every hour a facility fall policy outlined the control of the co	ny Resident #3 did not have ir alarm or increased checks I every 2 hours during the t night checks when the			
	Refer to interview with (PCA) on 01/08/19 at	h a personal care aide 6:45am.			
	Refer to interview with at 7:00am.	h a second PCA on 01/08/19			
	Refer to interview with 12:28pm.	h the RCD on 01/08/19 at			
	Refer to interview with 01/08/19 at 3:55pm.	h the Administrator on			
	09/05/18 revealed: -Diagnoses included urinary tract infections	t #4's current FL2 dated anxiety, dementia, recurrent s hypertension and seizures. mi-ambulatory with the use			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060153	B. WING		01/08/2019
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	,	
CARILLON ASSISTED LIVING OF M	AINT HILL	GARET WALLA S, NC 28105	ACE ROAD	
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
O9/27/18 revealed: -The resident was ser of a wheelchairThe resident required ambulationThe resident required toileting, bathing dress transfers. Review of Resident #4 revealed: -There was no accided dated 11/12/18A report dated 12/20/Resident #4 reports revealed an Ediagnosed with a fall a of the right humorous. Review of Resident #4 revealed: -A visit dated 11/13/18 with a right non-displated fracture. Resident #4 right arm to decrease weight bearing on the 3 weeksA visit dated 11/21/18 with increased pain. A worn at all times and rand to follow up in 4 weaks and rand to	A's current care plan dated mi-ambulatory with the use d limited assistance with d supervision with eating, sing grooming and d's Accident Reports nt report filled out for the fall f18 at 6:00pm revealed r bottom. d's Emergency Room (ER) R visit dated 11/12/18 and a non-displaced fracture d's orthopedic notes d's orthopedic notes d's orthopedic notes d's oumented Resident #4 fixed greater tuberosity was to wear a sling on the pain and swelling and no right arm and to follow up in deceds documented Resident #4 fixed order for the sling to be no active range of motion weeks. documented resident #4 guards to range of motion. for PT/OT for passive range eks and then active range of	D 270		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	CONSTRUCTION	(X3) DATE COMP	
				A. BOILDING			
		HAL060153		B. WING		01/	08/2019
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL		GARET WALLA S, NC 28105	ACE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 7		D 270			
	Review of Resident #4's progress notes revealed no documentation of interventions after every fall.						
	Review of Resident #4's Home Health Log Book revealed there was no PT/OT ordered or given to Resident #4.						
	November 2018. -Resident #4 ambula	evealed: #4 fell and broke her arr ted with her walker.					
	-Resident #4 did not have any interventions after her fallsResident #4 was checked on every 2 hours 7:00am-11:00pm and every hour 11:00pm to						
	11:00pm to 7:00am a	s were every hour from nd that was all we did. ny there was no fall mat, eased supervision.	bed				
	Coordinator (MCRCC reveled:	mory Care Resident Ca c) on 01/08/19 at 6:45an					
	11/12/18 and she ser -The every 2 hour che every hour at night w (MCU) policy.	w Resident #4 fell on at Resident #4 to the ER ecks during the day and as the Memory Care Un	iit				
	other than the norma day and every hour a	sed checks on Residen I every 2 hours during th t night. have a fall mat, bed or c	ne				
	on 01/08/19 at 12:28	sident Care Director (R0 om revealed: lovember 2018 and brol	•				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE	SURVEY
ANDILAN	or connection	IDENTIFICATION NOWIBER.	A. BUILDING:	A. BUILDING:		LLILD
		HAL060153	B. WING		01/	/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STA	ATE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL	MARGARET WALL	ACE ROAD		
			HEWS, NC 28105	T		
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 8	D 270			
	-There was no implementation of interventions with Resident #4 such as the use of a fall mat, bed or chair alarms or increased supervision other than the normal every 2 hours during the day and every hour at night.					
	member on 01/08/19 -He was concerned a related to ambulation -Resident #4 used a rand could not push the -Resident #4 could eawalker with one handed -He was aware of 2 of December and November and November was nothing in help prevent another -He expected the facil #4 at least every 15-3	and supervision. rolling walker to get around he walker one handed. asily fall trying to push the hther falls without injuries in mber, 2018 but not sure mplemented after her fall to fall. lity staff to watch Resident on minutes to provide ulation because Resident #4				
	revealed Resident #4 supervision greater th	on 01/08/19 at 3:53pm required increased nan every hour because of ing a walker and a fractured				
	3:55pm revealed: -Resident #4 fell and 11/12/18Resident #4 was cap walker even with a br the staff to help with a	broke her right arm on pable of ambulating with her roken arm but she did expect ambulation to prevent any f the limited use of the right				

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NAME OF PROWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOFT MARGARET WALLACE ROAD MATTHEWS, NO. 28105 PREPARA TAG D 270 Continued From page 9 She did not know why Resident #4 did not have a fall mat, bed or chair alarm or increased checks other than the normal every 2 hours during the day and every hour at high checks when the facility fall policy outline interventions. Refer to interview with a medication aide (MA) on 01/07/19 at 3-25pm. Refer to interview with a personal care aide (PCA) on 01/08/19 at 5-45sm. Refer to interview with the RCD on 01/08/19 at 12-25pm. Refer to interview with the RCD on 01/08/19 at 12-25pm. Refer to interview with the RCD on 01/08/19 at 12-25pm. Refer to interview with the Administrator on 01/06/19 at 3-35pm. Refer to interview with the Administrator on 01/06/19 at 3-35pm. Refer to interview with the Administrator on 01/06/19 at 3-35pm. Refer to interview with the Administrator on 01/06/19 at 3-35pm. Refer to interview with the Administrator on 01/06/19 at 3-35pm. Refer to interview with the Administrator on 01/06/19 at 3-35pm. Refer to interview with the Administrator on 01/06/19 at 3-35pm. Refer to interview with the Administrator on 01/06/19 at 3-35pm. Refer to interview with the Administrator on 01/06/19 at 3-35pm. Refer to interview with the Administrator on 01/06/19 at 3-25pm. Refer to interview with the Administrator on 01/06/19 at 3-25pm. Refer to interview with the Administrator on 01/06/19 at 3-25pm. Refer to interview with the Administrator on 01/06/19 at 3-25pm. Refer to interview with the Administrator on 01/06/19 at 3-25pm. Refer to interview with the Administrator on 01/06/19 at 3-25pm. Refer to interview with the Administrator on 01/06/19 at 3-25pm. Refer to interview with the Administrator on 01/06/19 at 3-25pm. Refer to interview with the Administrator on 01/06/19 at 3-25pm. Refer to interview with the Administrator on 01/06/19 at 3-25pm. Refer to interview with the Administrator on 01/06/19 at 3-25pm. Refer to intervi	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
CARILLON ASSISTED LIVING OF MINT HILL MATTHEWS, NC 28105 SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDERS PLAN OF CORRECTION (EACH OPERICATION MINISTER PRECEDED BY BLILL FACULATION OF LISE DEMTHETING INFORMATION) DEFICIENCY OF LISE DEMTHETING INFORMATION DEFICIENCY DATE OF LISE OF			HAL060153	B. WING		01/08/2019	
MATTHEWS, NC 28105 MATTHEWS	NAME OF PR	ROVIDER OR SUPPLIER					
PREFIX TAG REGULATORY OR LSO IDENTIFYING INFORMATION) D 270 Continued From page 9 -She did not know why Resident #4 did not have a fall mat, bed or chair alarm or increased checks other than the normal every 2 hours during the day and every hour at night checks when the facility fall policy outline interventions. Refer to interview with a medication aide (MA) on 01/07/19 at 3:25pm. Refer to interview with a personal care aide (PCA) on 01/08/19 at 6:45am. Refer to interview with a second PCA on 01/08/19 at 12:28pm. Refer to interview with a personal care aide (PCA) on 01/08/19 at 6:45am. Refer to interview with a personal care aide (PCA) on 01/08/19 at 12:28pm. Refer to interview with a CD on 01/08/19 at 12:28pm. Refer to interview with the Administrator on 01/08/19 at 3:55pm. 3. Review of Resident #5's current FL2 dated 10/15/18 revealed: -Diagnoses included dementia with behaviors, history of falls, and a coronary artery bypass graft. -The resident required limited assistance with ambulation and transfers. -The resident required limited assistance with ambulation and transfers. -The resident required limited assistance with ambulation and transfers.	CARILLO	ASSISTED LIVING OF I	MINT HILL		ACE ROAD		
-She did not know why Resident #4 did not have a fall mat, bed or chair alarm or increased checks other than the normal every 2 hours during the day and every hour at night checks when the facility fall policy outline interventions. Refer to interview with a medication aide (MA) on 01/07/19 at 3:25pm. Refer to interview with the Memory Care Resident Care Coordinator (MCRCC) on 01/08/19 at 6:45am. Refer to interview with a personal care aide (PCA) on 01/08/19 at 6:45am. Refer to interview with a second PCA on 01/08/19 at 7:00am. Refer to interview with the RCD on 01/08/19 at 12:28pm. Refer to interview with the Administrator on 01/08/19 at 3:55pm. 3. Review of Resident #5's current FL2 dated 10/15/18 revealed: -Diagnoses included dementia with behaviors, history of falls, and a coronary artery bypass graftThe resident was semi-ambulatory. Review of Resident #5's current care plan dated 11/26/18 revealed: -The resident was semi-ambulatoryThe resident required limited assistance with ambulation and transfersThe resident required dimited assistance with	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	:
toileting, bathing, dressing and grooming.	D 270	-She did not know wha fall mat, bed or chain other than the normal day and every hour at facility fall policy outling. Refer to interview with 01/07/19 at 3:25pm. Refer to interview with Care Coordinator (MC 6:45am. Refer to interview with (PCA) on 01/08/19 at Refer to interview with at 7:00am. Refer to interview with 12:28pm. Refer to interview with 12:28pm. Refer to interview with 12:28pm. 3. Review of Resident 10/15/18 revealed: -Diagnoses included on history of falls, and a graftThe resident was seren Review of Resident #11/26/18 revealed: -The resident required ambulation and transform -The resident required ambulation and transform.	y Resident #4 did not have r alarm or increased checks every 2 hours during the t night checks when the ne interventions. In a medication aide (MA) on the Memory Care Resident CRCC) on 01/08/19 at the Administrator on	D 270			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	DF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:	A. BUILDING:		LETED
		HAL060153	B. WING		01/	08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STA	ATE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL	MARGARET WALL	ACE ROAD		
- CARRIELO	N AGGIOTED EIVING OF	MAT1	HEWS, NC 28105	T		
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 10	D 270			
D 270	Review of Resident # revealed: -A report dated 11/21, Resident #5 fellA report dated 11/29, Resident #5 fell and opainA report dated 12/20, Resident #5 fell and opainA report dated 12/20, Resident #5 fell, hit hir ribs A report dated 01/04, Resident #5 fell out of Review of Resident # reports revealed: -An ER visit dated 11, An ER visit dated 12, multiple right sided of the right chest wall (AAA) without rupture. Review of Resident # no documentation of interview with a media 01/07/19 at 3:25pm re-Resident #5 fell and -Resident #5 did not her fallsThere was no fall maincreased supervision -The standard checks 11:00pm to 7:00am a	25's Accident Reports 27.18 at 8:30am revealed 27.18 at 8:56pm revealed 27.18 at 3:35pm revealed 27.19 at 2:30pm revealed 28.19 at 2:30pm revealed 29.19 at 2:30pm revea	D 270			
		mory Care Resident Care c) on 01/08/19 at 6:45am				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:	A. BUILDING:		LETED
		HAL060153	B. WING		01	/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
0.450.10		5601 N	IARGARET WALL	ACE ROAD		
CARILLO	N ASSISTED LIVING OF	MINT HILL MATTH	IEWS, NC 28105			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	= 11	D 270			
	-She knew Resident a sent to the ERThere was no increa other than the normal day and every hour a -The every 2 hour che every hour at night was (MCU) policyResident #3 did not la alarm. Interview with the Reson 01/08/19 at 12:28president #5 fell 12/2 ribsThere was no impler with Resident #5 sucl bed or chair alarms o	#5 fell on 12/20/18 and was sed checks on Resident #5 I every 2 hours during the t night. ecks during the day and as the Memory Care Unit have a fall mat, bed or chair sident Care Director (RCD) om revealed: 10/18 and received fractured mentation of interventions h as the use of a fall mat, or increased supervision I every 2 hours during the				
	#5's physician's office revealed: -The physician was a 11/21/18 and 12/20/1 -The physician signed Resident #5 to have 'non-skid socks and re Resident #5 was four and fallsThe physician was a Aneurysm(AAA) foun was not rupturedThe physician expectall orders a written/diin-The physician consid #5 at serious risk relations by the physician was relations with respirations.	8. d an order on 11/30/18 for 'increased visual checks, edirection" because nd in other resident's beds ware of the Abdominal Aortic d on the 12/20/18 fall that				

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STATE FORM MJQG11 If continuation sheet 12 of 44

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL060153	B. WING		01/08	3/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF I	MINT HILL	RGARET WALLA VS, NC 28105	ACE ROAD		
(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 CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	ULD BE	(X5) COMPLETE DATE
D 270	Continued From page	: 12	D 270			
	3:55pm revealed: -She was aware of Rewhich resulted in fraction resulted in fraction resident #5 used a versident #5 did not halarm or increased chevery 2 hours during in hightShe did not know what fall mat, bed or chain other than the normal day and every hour at facility fall policy outling. Telephone interview with member on 01/08/19 unsuccessful. Refer to interview with 01/07/19 at 3:25pm. Refer to interview with Care Coordinator (MC 6:45am. Refer to interview with (PCA) on 01/08/19 at Refer to interview with at 7:00am.	wheelchair for ambulation. have a fall mat, bed or chair lecks other than the normal the day and every hour at y Resident #4 did not have r alarm or increased checks every 2 hours during the thight checks when the he interventions. with Resident #5's family at 1:33pm was he a medication aide (MA) on the Memory Care Resident CRCC) on 01/08/19 at he a personal care aide 6:45am. he a second PCA on 01/08/19 he the RCD on 01/08/19 at				

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STATE FORM MJQG11 If continuation sheet 13 of 44

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL060153	B. WING		01/08/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE	
		5601 M	ARGARET WALL	ACE ROAD	
CARILLO	N ASSISTED LIVING OF	MINT HILL MATTH	EWS, NC 28105		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
D 270	Continued From page	e 13	D 270		
	Interview with a media 01/07/19 at 3:25pm re-After a resident fell, the filled out. -The accident report with the Health and Wellnest they were responsible interventions at that tising 4 24 hour log book with the filled which included a the normal checks of every 2 hours during night.	cation aide (MA) on evealed: there was an accident report was the documentation of who was informed. was given to the RCD and ess Director (HWD) and e for any implementation of ime. was kept on all residents with any new interventions. on residents in the MCU is the day and every hour at			
	Coordinator (MCRCC) reveled: -An accident report we resident after each father	ined information about the fied. Is completed every shift and in such as falls, injuries, and in entation for normal every every 2 hour checks during checks if needed. In onal care aide (PCA) on evealed: ICU on 3rd shift. ICU on 3rd shift. ICU seed checks on residents			
		or bed alarms, or fall mats			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL060153	B. WING		01	/08/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL	ARGARET WALLAC	E ROAD		
OARTIELO	A AGGIOTED EIVING OF	MATTH	EWS, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From pag	e 14	D 270			
D 270	Interview with a second 7:00am revealed: -The normal rounds the day and every hour there were no bed in the MCUHe was never instruction on the result of the was never instruction on any result of the was never instruction. Interview with the RC revealed: -An accident report were sident with a fallA resident would be resident with a fallA resident would be resident hit their hears of the word of the wo	were every 2 hours during our at night in the MCU. or chair alarms, or fall mats acted to increase checks or esidents in the MCU. Incred to implement any fall resident in the MCU. CD on 01/08/19 at 12:28pm Invas filled out on each In sent out to the ER if the d. In any use of fall mats, bed or ased supervision on any ased supervision in the MCU by were checking on residents an in the assisted living side. If all interventions after a fall. In a sum of the fall policy with a sum of the fall policy with a sum of the sum				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL060153	B. WING		01	/08/2019
	ROVIDER OR SUPPLIER	MINT HILL 5601 MA	DDRESS, CITY, STATE NRGARET WALLAC EWS, NC 28105			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 270	with the family, physichigher level of careShe did not know who did not have a fall maincreased checks oth hours during the day checks when the faci interventions. The facility failed to a and #5) were supervited their needs which if falling which resulted visits which included blood thinner, another sustaining a fractured resident (#5) falling of This failure resulted in neglect to these resident (Violation. The facility provided a accordance with G.S this violation.	she would have a meeting cian, and HWD to discuss a my Resident #3, #4 and #5 at, bed or chair alarm or er than the normal every 2 and every hour at night lity fall policy outline ssure that residents (#3, #4 sed appropriately according resulted in one resident (#3) in five emergency room head injuries while on a resident (#4) falling a re	D 270			
D 273	•		D 273			

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PRINTED: 01/30/2019 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		o.	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
		1141 000450		B. WING		04/	20/2040
		HAL060153				01/0	08/2019
NAME OF P	ROVIDER OR SUPPLIER	\$	STREET ADDRI	ESS, CITY, STAT	TE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL		ARET WALLA	ACE ROAD		
	T		MATTHEWS,	NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	I .	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 273	Continued From page	e 16		D 273			
	reviews, the facility fa follow-up for 2 of 4 sa #1, and #4) Resident notified of medication not being referring to	as evidenced by: ns, interviews and record illed to assure referral and impled residents (Reside #1 whose physician was refusals and Resident #4 Physical Therapy and y after a fractured arm.	d nt not				
	The findings are:						
	09/14/18 revealed dia	t #4's current FL2 dated agnoses included dement tinfections, hypertension					
	physical and occupat range of motion for 3 motion. -A physical therapy p medical necessity sig physician for passive then active range of r	ian order dated 12/20/18 ional therapy for passive weeks then active range rescription and letter of ned by Resident #4's range of motion for 3 we notion.	of eks				
	revealed: -On the 12/20/18 visit therapy and occupation	with Resident #4's on 01/08/19 at 3:53pm the wrote for physical onal therapy to work with e range of motion to help					

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(3) DATE SURVEY COMPLETED	
				_			
		HAL060153		B. WING		01	/08/2019
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARILLO	N ACCICTED I IVING OF	MINT LIII I	5601 MAR	GARET WALLA	CE ROAD		
CARILLO	N ASSISTED LIVING OF	MINI HILL	MATTHEW	S, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE OF MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From pag	e 17		D 273			
	mobility of the right a -He expected the fac started on physical th Resident #4's right a		hen Is from				
	Coordinator (MCRCC revealed: -She did not know th therapy/occupational -The Resident Care I Health and Wellness	emory Care Resident C) on 01/08/19 at 6:45 ere was an order for p therapy for Resident Director (RCD) and th Director (HWD) were w orders and referrals	5am bhysical #4. e				
	therapy/occupational	evealed: ere was an order for p therapy for Resident WD were responsible	#4.				
	member on 01/08/19 -He was with Reside office on 12/20/18 wl physical and occupar -The therapy was to her arm after almost -Resident #4 was rig strength back to help -He expected the fact and occupational the physician to help pre #4 could not ambulat was not getting assis -Resident #4 fell late to the Orthopedics' of	nt #4 at the Orthoped nen the physician orde	ics' ered the ngthen g it. d the r. ysical le esident and n. er visit ause				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		HAL060153	B. WING		01	/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL	ARGARET WALLAC	E ROAD		
	T		EWS, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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) COMPLETE DATE
D 273	Continued From pag	e 18	D 273			
	hand.					
	a home health agend	sical Therapy Assistant from by on 01/08/19 at 12:25pm no referral made to their #4.				
	revealed:	CD on 01/08/19 at 12:28pm				
	-She did not know th Resident #4 to have therapy.	ere was an order for physical and occupation				
	new orders.	HWD was responsible for all				
	order documenting s	onfirmed on the physician's he faxed the order to the				
	orders to the pharma	e for faxing this new set of acy and then calling home all and occupational therapy.				
		ministrator on 01/08/19 at				
	occupational therapy	t #4's order for physical and came in, she and the RCD all orders being faxed to the				
	pharmacy and conta- -The RCD received t	cting any referral agencies. he order for Resident #4's tional therapy, and faxed the				
	order to the pharmachealth agency and se	by but did not call the home et up the therapy.				
	order was faxed to the	eferral to be made after the ne pharmacy. nt #1's current FL-2 dated				
	06/29/18 revealed di	agnoses included other infarction, muscle weakness				
	Review of Resident #	#1's record revealed:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING:				
				7.1. 55.125.11.51			
		HAL060153		B. WING		0	1/08/2019
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
0450110	N 40010TED N/INO 0E		5601 MAR	SARET WALLA	ACE ROAD		
CARILLO	N ASSISTED LIVING OF	MINI HILL	MATTHEW	S, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273				D 273			
	PCP dated 11/27/18 continued to refuse F -There was a visit sur PCP dated 12/11/18 sent an order to the f Resident #1's Flomax -There was no docum had been notified reg Miralax, Pro-Stat or f -Resident #1's last do was dated 12/04/18. a. Review of Resident	mmary from Resident # documenting the PCP acility to discontinue x due to non-use. nentation Resident #1's parding her refusals of amotidine. becomented visit with he at #1's current FL-2 dat medication order for Mi	#1 #1's had s PCP er PCP				
	(eMAR) revealed: -There was an entry administered daily at -There was documental administered for 29 of	for Miralax 17gm to be 8:00am. Itation Miralax had bee of 30 opportunities. Itation Resident #1 refu	n				
	revealed: -There was an entry administered daily at -There was document administered for 11 or administered for 20 of 3	ntation Miralax had bee of 31 opportunities. Itation Resident #1 refu 31 opportunities. Itation Resident #1 refu secutive doses from and again for 11	n used				

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STATE FORM 6899 MJQG11 If continuation sheet 20 of 44

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL060153	B. WING		01	/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREE	FADDRESS, CITY, STATE	E, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL	MARGARET WALLAC	CE ROAD		
(VA) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	HEWS, NC 28105	PROVIDER'S PLAN OF	CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From pag	e 20	D 273			
	12/31/18.					
	revealed: -There was an entry administered daily at -There was documer the Miralax for 7 of 7 through 01/07/19). Observation of Residualiable for adminis	for Miralax 17gm to be 8:00am. Intation Resident #1 refused opportunities (01/01/19 Ident #1's medications tration on 01/08/19 at tralax was available for				
	revealed: -The only medication were aspirin, Tylenol -She had been expersome of her medicate might be causing her -She was taking Flor when her Primary Cardiscontinued itSince the discontinue had mostly resolved experienced two epis	nax up until December 2018 are Provider (PCP) ation of Flomax, her diarrhea and she had only				
	resident thought it ca -She could not remer complaining of any re -If a resident routinel	revealed: fused Miralax because the used her to have diarrhea.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED	
		HAL060153	B. WING		0,	1/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	. ZIP CODE		
			ARGARET WALLAC			
CARILLO	N ASSISTED LIVING OF	MINT HILL	EWS, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 273	notify the resident's Resident #1's medical Interview with the RC revealed: -Resident #1 refused she thought they gave-Resident #1 first the causing her diarrhead discontinued it, but "medications." -She had educated Fimportance of taking -The facility did not howhen the PCP should missed medications, "consistently" refusing and the RCD's responses and the RCD's responses and the RCD's responses and the RCD's response typically reported during her weekly visher anything unless a medicationShe had verbally reported the first week in Deconsess and the RCD's response to the first week in Deconsess and the RCD's response to the first week in Deconsess and the RCD's response to the first week in Deconsess and the RCD's response to the first week in Deconsess and the RCD's resident refusals and the RCD's response to the RCD's r	RCD's responsibility to PCP of refusals the RCC and RCD aware of ation refusals. CC on 01/08/19 at 12:30pm The medications because the her diarrhea. The regarding the all her ordered medications. The average as pecific policy on the policy of the po	D 273	DEFICIENCY		
	conversation with Re -If the PCP had given have been given to the -She was not in the f	e outcome of the PCP's sident #1. In any new orders, they would ne former RCD. It is acclibled a control of the PCP's most not sure what the RCD might				

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STATE FORM MJQG11 If continuation sheet 22 of 44

DIVISION	n Health Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPI	LETED
	HAL060153		B. WING		04/	08/2019
		HAL000133			1 01/	00/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
04511101		5601 MAF	RGARET WALL	ACE ROAD		
CARILLUI	N ASSISTED LIVING OF I	MATTHE\	WS, NC 28105			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO	ULD BE	COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
			1	DEFICIENCY)		
D 273	Continued From page	e 22	D 273			
	Interview with the DC	D on 01/09/10 of 12:45pm				
		D on 01/08/19 at 12:45pm				
	revealed:	facility for any county				
	-She had been at this					
		e last time Resident #1's				
	PCP visited the facility					
	-She did not know abo	out Resident #1's				
	medication refusals.					
		e would have contacted the				
		than wait until her next visit.				
	-Resident #1 was not	seen by her PCP on				
	01/01/19.					
	Intorvious with the Adr	ministrator on 01/08/19 at				
	3:50pm revealed:	Tillistrator on 01/06/19 at				
	-	ave a specific policy on				
	when a resident's PC					
	regarding medication					
		oout medication refusals				
		uation" and was typically				
	based on consecutive	• • • • • • • • • • • • • • • • • • • •				
	medication.	relusais of the same				
		sident #1's refusal of Flomax				
		ut her refusals of any other				
	medications.	at his roladale of ally other				
	-With Resident #1 ref	using Miralax for 18				
		he would have expected the				
		nt #1's PCP regarding each				
	of the medications.	it ii i or or regarding eden				
		RCD's responsibility to notify				
	the PCP.	in a second second second				
		could be done verbally				
		via paperwork sent out with				
	a resident to a PCP v					
		PCP should be documented				
	in the resident's recor					
	1.0 100.001110 10001					
	Attempted telephone	interview with Resident #1's				
		0:38am was unsuccessful.				

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HAL060153 B. WING 01/03	
HAL060153 B. WING 01/08	3/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
CARILLON ASSISTED LIVING OF MINT HILL 5601 MARGARET WALLACE ROAD MATTHEWS, NC 28105	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
b. Review of Resident #1's current FL-2 dated 06/29/18 revealed a medication order for Pro-Stat 30mL daily (a protein supplement). Review of Resident #1's November 2018 eMAR revealed: -There was an entry for Pro-Stat 30mL to be administered daily at 8:00am. -There was documentation Pro-Stat had been administered for 29 of 30 opportunities. -There was documentation Resident #1 refused the Miralax for 1 of 30 opportunities. Review of Resident #1's December 2018 eMAR revealed: -There was an entry for Pro-Stat 30mL to be administered daily at 8:00am. -There was an entry for Pro-Stat had been administered daily at 8:00am. -There was documentation Pro-Stat had been administered for 16 of 31 opportunities. -There was documentation Resident #1 refused the Pro-Stat for 15 of 31 opportunities. -There was documentation Resident #1 refused the Pro-Stat for 5 consecutive doses from 12/29/18 through 12/31/18. Review of Resident #1's January 2019 eMAR revealed: -There was an entry for Pro-Stat 30mL to be administered daily at 8:00am. -There was an entry for Pro-Stat 30mL to be administered daily at 8:00am. -There was documentation Resident #1 refused the Pro-Stat for 7 of 7 opportunities. Observation of Resident #1's medications available for administration on 01/08/19 at 11:43am revealed Pro-Stat was available for administration.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060153	B. WING		01	//08/2019
NAME OF B	ROVIDER OR SUPPLIER	ether.	T ADDRESS, CITY, STAT	F. 71D CODE	,	
NAIVIE OF P	ROVIDER OR SUPPLIER		IARGARET WALLA			
CARILLO	N ASSISTED LIVING OF	MINT HILL	HEWS, NC 28105	CE ROAD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	COMPLETE DATE
D 273	Continued From page	e 24	D 273			
	were aspirin, Tylenol,	s she was currently taking metoprolol and Lasix. d Pro-Stat because she did				
	Interview with a MA on 01/08/19 at 11:43am revealed: -Resident #1 often refused the Pro-Stat because the resident thought it caused her to have diarrheaIf a resident routinely refused medications, she would notify the RCC and Resident Care Director (RCD)It was the RCC and RCD's responsibility to notify the resident's PCPShe had made both the RCC and RCD aware of Resident #1's medication refusals.					
	revealed: -Resident #1 refused she thought they gave -Resident #1 first thou causing her diarrhea discontinued it, but "n medications." -She had educated R importance of taking a -The facility did not ha	ught it was the Flomax so the PCP had now she thinks it's other esident #1 regarding the all her ordered medications. ave a specific policy on				
	missed medications, "consistently" refusing and the RCD's respoi -Resident #1's PCP v -She typically reporte during her weekly vis	g a medication, it was her nsibility to notify the PCP. isited the facility weekly. d patient needs to the PCP it and rarely called or faxed resident needed a refill on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY LETED
AND I EARL OF COURTED HOLD	IBERTII 10	WHO WHO MELT	A. BUILDING: _			
	HAL06	0153	B. WING		01/	08/2019
NAME OF PROVIDER OR SUPPLIE	R	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARILLON ASSISTED LIVIN	G OF MINT HILL	5601 MAR	GARET WALLA	ACE ROAD		
		MATTHEW	S, NC 28105			
PREFIX (EACH DEF	RY STATEMENT OF DEI CIENCY MUST BE PREC Y OR LSC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
the first week in She could not in the conversation would be in Researche PCP said about her medication with the PCP had about her medication with the PCP had have been given. The RCC was most recent vision might have disconsidered with the revealed: She had been she was working PCP visited the The RCD did in medication refuriles had know PCP via phone resident #1 was 01/01/19. Interview with the 3:50pm reveale The facility did when a resident regarding medication. She knew about the convergence of the production of the production of the production of the production.	sals during the PCI December 2018. emember if she had anywhere, but if stident #1's progress the would talk with ation refusals. It know the outcomb Resident #1. given any new ord to the former RCI and was not sure ussed with the PCI et and was not sure ussed with the PCI et and the facility for orang the last time Resident #1. The state of the facility for orang the last time Resident #1. The state of the facility on 01/01/15 of the would have the state of the would have the state of the work with the PCI et al. The would have the would have the would have the work with the pci et al. The would have the work would have the work with the pci et al. The work would have the work would have the work would have a specific the pci and the work as specific to the pci and the work as specific to the pci and the work as specific to the pci and the pci an	ad documented she had, it is notes. Resident #1 The of the PCP's ers, they would D. Turing the PCP's what the RCD P. 9 at 12:45pm The week. Sident #1's P. The contacted the till her next visit. PCP on 01/08/19 at Proposition political on refusals as typically the same Tusal of Flomax is of any other	D 273			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
		HAL060153	B. WING		01	/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CABILLO	N ACCIOTED I IVINO OF	5601 MAF	RGARET WALL	ACE ROAD		
CARILLO	N ASSISTED LIVING OF	MATTHE\	NS, NC 28105			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 26	D 273			
D 273	consecutive doses, s staff to notify Resider of the medications. -It was the RCC and the PCP. -Notification to PCP's during a visit, via fax, a resident to a PCP v-All contacts with the in the resident's record. Attempted telephone PCP on 01/08/19 at 1 c. Review of Resider 06/29/18 revealed a r famotidine 20mg daily gastroesophageal reference was an entry from the famotidine for 29 or 1-There was document the famotidine for 1 or 1-There was an entry from the famotidine for 1 or 1-There was document the famotidine for 15	the would have expected the at #1's PCP regarding each RCD's responsibility to notify a could be done verbally via paperwork sent out with isit or via telephone. PCP should be documented and. Interview with Resident #1's 0:38am was unsuccessful. Int #1's current FL-2 dated medication order for y (a medication used to treat flux disease and heartburn). It's November 2018 eMAR for famotidine 20mg to be 8:00am. tation famotidine had been f 30 opportunities. tation Resident #1 refused f 30 opportunities. It's December 2018 eMAR for famotidine 20mg to be 8:00am. tation famotidine had been f 31 opportunities. tation famotidine had been f 31 opportunities. tation Resident #1 refused of 31 opportunities. tation Resident #1 refused of 31 opportunities.	D 273			
	administered for 16 o -There was documen the famotidine for 15 -There was documen the famotidine for 6 c	f 31 opportunities. tation Resident #1 refused of 31 opportunities. tation Resident #1 refused onsecutive doses from and again for 3 consecutive				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			3) DATE SURVEY COMPLETED	
		HAL060153		B. WING		0.	1/08/2019
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL		SARET WALLA S, NC 28105	ACE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 27		D 273			
	revealed: -There was an entry fadministered daily at -There was documen administered for 3 of -There was documen the famotidine for 4 o -There was documen the famotidine for 3 c 01/02/19 to 01/05/19. Observation of Residavailable for administ 11:43am revealed far for administration. Interview with Reside revealed: -The only medications were aspirin, Tylenol, -She "was not familia knew she wasn't takin Interview with a MA or revealed: -Resident #1 often rebecause the resident have diarrheaIf a resident routinely would notify the RCC (RCD)It was the RCC and the resident #1's medical Interview with the RCC.	tation famotidine had be 7 opportunities tation Resident #1 refus f 7 opportunities. It 7 opportunities tation Resident #1 refus onsecutive dose from ent #1's medications ration on 01/08/19 at notidine 20mg was avail on the famotidine and Lasix. It with famotidine, but sing it. In 01/08/19 at 11:43am fused the famotidine thought it caused her to a refused medications, sand Resident Care Direct RCD's responsibility to retused medication to the RCC and RCD aware thought it caused the resident RCD aware thought it caused the famotidine thought it caused her to the RCC and RCD aware the RCC and RCD aware the refused medication to the RCC and RCD aware thought it caused the famotidine thought it caused her to the RCC and RCD aware the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the refused medication to the RCC and RCD aware the RCC and RCCD aware the RCCC and RCCD aware the RCC and RCCD aware the RCC and RCCD aware the RCC awar	e een eed eed eed eed eed eed eed eed ee				
	revealed:						

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DIVISION	n nealth Service Regu	liation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(>	X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		BIIII DING:		COMPLI	ETED
			^	50.25.140			
		HAL060153	В	8. WING		01/0	8/2019
						1 0 170	0.2010
NAME OF PI	ROVIDER OR SUPPLIER	ST	REET ADDRES	SS, CITY, STAT	E, ZIP CODE		
04511101		56	01 MARGA	RET WALLA	CE ROAD		
CARILLUI	N ASSISTED LIVING OF	MINI HILL MA	ATTHEWS, N	NC 28105			
0/4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		ID.	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
D 273	Continued From page	e 28	[D 273			
	Docidont #1 refused	her medications because					
	she thought they gave						
		ught it was the Flomax					
	causing her diarrhea						
	discontinued it, but "n	now she thinks it's other					
	medications."						
	-She had educated R	lesident #1 regarding the					
	importance of taking a	all her ordered medications	s.				
		ave a specific policy on					
	•	be notified regarding					
	missed medications, but if a resident was						
		g a medication, it was her					
	_	-					
	-	nsibility to notify the PCP.					
		visited the facility weekly.					
		d patient needs to the PCF					
	•	it and rarely called or faxed					
	her anything unless a	a resident needed a refill or	1				
	medication.						
	-She had verbally rep	oorted Resident #1's					
	medication refusals d	luring the PCP's facility visi	t				
	the first week in Dece	-					
	-She could not remen	mber if she had documente	d l				
		where, but if she had, it					
	would be in Resident						
		ould talk with Resident #1					
	about her medication						
)'o				
		ow the outcome of the PCP	's				
	conversation with Res						
		any new orders, they wou	ıld				
	have been given to the						
	-The RCC was not in	the facility during the PCP	's				
	most recent visit and	was not sure what the RCI	D				
	might have discussed	d with the PCP.					
	-						
	Interview with the RC	D on 01/08/19 at 12:45pm					
	revealed:						
		facility for one week.					
		e last time Resident #1's					
	PCP visited the facilit	y on 01/01/19.					

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-The RCD did not know about Resident #1's

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIT LETED	
		HAL060153	B. WING		01/08/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL	GARET WALLA /S, NC 28105	ACE ROAD		
	CLIMMADY CT		1	DDOWNERIC DI ANI OF CORRECTIO	INI	\dashv
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE	≣
D 273	Continued From page	29	D 273			
		e would have contacted the than wait until her next visit. seen by her PCP on				
	3:50pm revealed: -The facility did not hawhen a resident's PC regarding medication -Notifying the PCP about did not have medicationShe knew about Result did not know about medicationsWith Resident #1 reficonsecutive doses, slight for notify Resident of the medicationsIt was the RCC and light the PCPNotification to PCP's during a visit, via fax, a resident to a PCP vial contacts with the in the resident's record.	refusals. refusals. refusals detailed and was typically a refusals of the same refusals of the same refusals of the same refusals of any other responsibility to refusal the refusals of any other responsibility to refusal the refusals of any other refusals of any other refusals of the same refusal				
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276			
	following in the reside	ssure documentation of the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			3) DATE SURVEY COMPLETED	
		HAL060153		B. WING		01	//08/2019
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CABILLO	N ASSISTED LIVING OF	MINIT LIII I	5601 MAR	GARET WALLA	ACE ROAD		
CARILLO	N ASSISTED LIVING OF	WIINT FILL	MATTHEW	S, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	e 30		D 276			
	a physician or other li and (4) implementation of orders specified in Su Rule.	censed health profes	nts or				
	This Rule is not met Based on interviews, observations the facil physician's orders we sampled residents (R to be worn at all times The findings are:	record reviews and ity failed to assure are implemented, for 1 esident #4) related to					
	Review of Resident # 09/14/18 revealed dia recurrent urinary tractand seizures.	agnoses included den	nentia,				
	Review of Resident # order dated 11/13/18 Resident #4 to use a weight bearing for rig	revealed an order for right arm sling, and n	-				
	Review of Resident # order dated 11/21/18 Resident #4 to use a and no active range of	revealed an order for right arm sling at all t	imes,				
	Review of Resident # electronic Medication -There was no entry f slingAn order transcribed	Record (eMAR) rever for Resident #4 to we	ar a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060153	B. WING		01	/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, STAT	TE. ZIP CODE	•	
		5601	1 MARGARET WALLA			
CARILLO	N ASSISTED LIVING OF	MINT HILL MAT	THEWS, NC 28105			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	e 31	D 276			
		I 11/01/18 - 11/30/18 on t, 3:00pm - 11:00pm shift am shift.				
	revealed: -There was no entry f slingAn order transcribed arm was documented	4's December 2018 eMAR for Resident #4 to wear a as no weight bearing right 1 12/01/18 - 12/31/18 on t, 3:00pm - 11:00pm shift am shift.				
	revealed: -There was no entry f slingAn order transcribed arm was documented	4's January 2019 eMAR for Resident #4 to wear a as no weight bearing right 101/01/19 - 01/08/18 on t, 3:00pm - 11:00pm shift am shift.				
	10:09am revealed the	dent #4 on 01/07/19 at e sling on her right arm was e right arm to hang down ou	t			
	•	ent #4 on 01/07/19 at e did not have her sling on walker with her left hand.				
	revealed: -Resident #4 was to vice since her fall on 11/13 -The sling was to prepainHe expected the faci	on 01/08/19 at 3:53pm wear a sling all the time				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
		HAL060153	B. WING		01/0	08/2019
NAME OF F	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	1 01/0	00/2013
		5601 MAR	GARET WALLA	,		
CARILLO	N ASSISTED LIVING OF	MATTHEY	VS, NC 28105			_
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 276	Continued From page 32		D 276			
	Coordinator (MCRCC revealed: -She did not know the to be worn at all time: -Resident #4 came be orthopedics office wit -Resident #4 did not she did not know who mornings or took it of -The Resident Care II Health and Wellness responsible for all ner-The only knew of the on the eMAR. Interview with the RC revealed: -Resident #4 wore as the fall in November 2-She did not know the timesResident #4 did not because Resident #4-She would see Resident #4-She word as wear the sling at all till Interview with a Mem aide (PCA) on 01/08/-Resident #4 wore as of the timeResident #4 did not see Resident #4-She would	ack from a visit to the h it on. wear the sling at times. no put the sling on in the f in the evening. Director (RCD) and the Director (HWD) were w orders. e non-weight bearing order D on 01/08/19 at 6:45am sling on her right arm after 2018. e sling was to be worn at all wear the sling all of the time would take it off. dent #4 with the sling on but nging down and out of the g with her walker. e eMAR was for non-weight 4's right arm and she did in order for Resident #4 to				

times.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060153	B. WING		0.	1/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E. ZIP CODE	•	
		5601 M	ARGARET WALLAC			
CARILLO	N ASSISTED LIVING OF	MINT HILL MATTH	EWS, NC 28105			
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	e 33	D 276			
	out of the sling many her walkerSometimes she wou back in the sling after Interview with a second 7:00am revealed: -He saw the sling befine the morningsResident #4 used a spulled the right arm outled the right arm	4 with her right arm hanging times while ambulating with ld put Resident #4's arm Resident #4 sat down. Ind MC PCA on 01/08/19 at ore on Resident #4. Typically got Resident #4 up walker to ambulate and ut of the sling to ambulate. It to fit the sling on correctly instruction or training to do				
	know the right arm wa -Resident #4 came ba office visit with a sling -She did not know the sling at all times. -She was not given a the sling on or how to -The RCD and the Nu new orders. Telephone interview was	evealed: ovember 2018, and did not as broken for 3 weeks. ack from the Orthopedic g on. ere was an order to wear the ny instructions on how to put o adjust the sling. urse were responsible for all with Resident #4's family at 1:33pm revealed:				
	office on 11/13/18 wh sling to be worn on R help with pain and sw -He took Resident #4 office on 11/21/18 be swelling.	nt #4 at the Orthopedics' en the physician ordered the esident #4's right arm to velling. back to the Orthopedic cause of increased pain and ered the sling to be worn at				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL060153	B. WING		01	/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL	ARGARET WALLA EWS, NC 28105	ACE ROAD		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 276	Resident #4 at all time-Resident #4 complainthere even after taking - He saw Resident #4 but thought it was to be until Interview with the RC revealed: -She knew Resident #4 the right arm but did recontinuous. -She was responsible pharmacy and making reflected on the eMAI - She along with the Nonew orders. -The new orders were eMAR after the new eaccuracy. -The order for Reside all time was missed. -The order for Reside bearing was on the elform the same order sit was missed. Interview with the Adra 3:55pm revealed: -She and the RCD we orders up until a monimized. -The order dated 11/1 pharmacy for Resider bearing of the right arwas the only order the	lity staff to keep the sling on es to help with the pain. ned to him the pain was still g the pain medications. at meals without the sling pe off during meals. D on 01/08/19 at 12:28pm 44 was to wear the sling on not know the order was for for faxing the orders to the g sure all orders were R correctly. The large was responsible for all the et al. AR was printed off for ent #4's sling to be worn at ent #4 to have non-weight MAR and since they were she could not figure out how ministrator on 01/08/19 at the ere responsible for all new the ago when the HWD was 13/18 was faxed to the ent #4's sling and no weight me but the no weight bearing at made it to the eMAR. In the HAR was a sling should the eMAR to be	D 276			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060153	B. WING		01/08/2019
	ROVIDER OR SUPPLIER	MINT HILL 5601 MA	DDRESS, CITY, STAT RGARET WALLA WS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 276		checked by the RCD at the ong with the orders to verify	D 276		
D 280	registered nurse, occuphysical therapist in the evaluation of the residual plan and care provide (a) of this Rule, is condays of admission or a resident develops the least quarterly thereas following: (1) performing a physical resident as related to current condition requests specified in Part (2) evaluating the resident as needed by assessment and evaluation and evaluation and evaluation and evaluations.	Licensed Health assure that participation by a supational therapist or the on-site review and dents' health status, care d, as required in Paragraph appleted within the first 30 within 30 days from the date the need for the task and at ofter, and includes the sical assessment of the the resident's diagnosis or siring one or more of the agraph (a) of this Rule; sident's progress to care the ased on the physical suation of the progress of the activities in Subparagraphs	D 280		
	reviews, the facility fa	as evidenced by: s, interviews, and record iled to assure an on-site essional Support (LHPS)			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
ANDIEAN	or connection	IDENTIFICATION NOME	JEIN.	A. BUILDING:		COM		
		HAL060153		B. WING		01	/08/2019	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CARILLO	N ASSISTED LIVING OF	MINT HILL		GARET WALLA S, NC 28105	ACE ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
D 280	for 1 of 4 sampled re required application sling. The findings are: Review of Resident and seizures. Review of Resident and seizures are recorded at 11/13/18. Resident #4 to use and weight bearing for right arm. Review of Resident and no active range. Interview with the Lift 12:19pm revealed:	n was completed quartersidents (Resident #4) wand removal of a right a #4's current FL2 dated agnoses included dement infections, hypertensions are was a revealed an order for a right arm sling, and no other than the standard properties are was a revealed an order for a right arm sling at all time of motion for right arm. #4's LHPS review reveaument or review on Residue and a sling at all time on the standard properties are sling at all time on the sling at all time	entia, on an nes, aled dent sulted her	D 280				
	-A list of all residents new LHPS was left for week by the RCD. -She did not know Roupdated LHPS.	for the facility in Decent that required an update or her at the facility even esident #4 required an esident Care Director (Repm revealed:	ed or ry					
	on 01/08/19 at 12:28		•					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL060153	B. WING		01/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E. ZIP CODE	,
		5601 MA	RGARET WALLA		
CARILLO	N ASSISTED LIVING OF I	MATTHE	WS, NC 28105		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 280	Continued From page	37	D 280		
	2018The LHPS Nurse wa reviews and evaluationshe was responsible know when there was residents that required she did not let the LHR esident #4. Telephone interview who orthopedic Physician revealed Resident #4 time since her fall on linterview with the Adra 3:55pm revealed: -The RCD was responsible know about ne change in a resident for the LHPS Nurse was evaluations and reviet facilityThe new LHPS Nurse was evaluated LHPS or a cluber that would be supported that would be supported to the RC Nurse of the residents assessments, change assessments, change in the supported to the residents assessments, change in the supported that would be supported to the RC Nurse of the residents assessments, change in the supported to the residents assessments, change in the supported to the residents assessments, change in the residents assessments.	es responsible for all LHPS ons. If or letting the LHPS Nurse is a significant change in the danew LHPS task. HPS Nurse know about with Resident #4's on 01/08/19 at 3:53pm was to wear a sling all the 11/13/18. ministrator on 01/08/19 at misible for letting the LHPS w residents or a significant for their LHPS tasks. Is responsible for all ws on all residents in the e was given the information was new, required an nange that required a new CD to inform the LHPS is that required the es and reviews. Is sident #4 did not have a			
D 375		i(a) Self-Administration Of	D 375		
	10A NCAC 13F .1005	Self -Administration Of			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL060153		B. WING		0.	1/08/2019
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	ΓE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINT HILL		SARET WALLA	CE ROAD		
	1		MATTHEWS	S, NC 28105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FILES CIDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 375	Continued From page	e 38		D 375			
	who are competent a self-administer their requirements are me (1) the self-administration physician or other perescribe medication documented in the re (2) specific instruction	medications if the follow t: ation is ordered by a rson legally authorized s in North Carolina and	ving I to				
	This Rule is not met Based on observation reviews, the facility fasampled residents (Figure 1997) physician's order for medication. The findings are:	ns, interviews, and reco alled to assure 1 of 1 Resident #2) had a	ord				
	Review of Resident # revealed: -Diagnoses included metabolic/toxic encepand agitationThere was no order self-administer Flutic prevent nasal inflammeach nostril twice permedication used to trand shortness of breafour times per day as	altered mental status, a chalopathy slowly improfor Resident #2 to asone (a medication us mation) 50mcg 1 spray day and Albuterol (a reat and prevent wheez ath) 90mcg to inhale 2 a needed for wheezing.	acute oving, sed to in zing puffs				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL060153	B. WING		0	1/08/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE			
CARILLO	N ASSISTED LIVING OF	MINT HILL 5601 M	ARGARET WALLAC	E ROAD			
		MATTH	EWS, NC 28105				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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) COMPLETE DATE	
D 375	December 2018 and -There was no docu Resident #2 was abl her medicationsThere was no order Resident #2's bedsic -An order transcribe spray in each nostril -An order transcribe a day as needed for Observation of Resic hand on 01/8/19 at no Fluticasone 50mc twice per day) and A puffs four times per available on the med Observation of Resic 11:40am revealed F Resident #3's locked Interview with a med at 11:45am revealed -She was not familia Fluticasone or the A -She had not admini medications to Resic Observation of the N 01/8/19 at 11:50am -The MA asked Resi Fluticasone or Albutt Resident #2 informe Fluticasone and the -Resident #3 informed	I January 2019 revealed: mentation on the MARs that e to self-administer any of to keep medications at de. d for Flonase spray 50mcg 1 twice a day. d for Albuterol 2 puffs 4 times wheezing. Ident #2's medications on I1:40am revealed there was eg (1 spray in each nostril albuterol 90mcg (to inhale 2 day as needed for wheezing) dication cart. Ident #2's room on 01/08/19 at lonase and Albuterol in d nightstand drawer. Ilication aide (MA) on 01/8/19 I: r with Resident #2 taking the libuterol. stered neither of the dent #2. If A in Resident #2's room on revealed: dent #2 had she ever taken erol. d the MA she had both the Albuterol in her room.	D 375				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
HAL060153		B. WING		01/08/2	019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		5601 MAF	RGARET WALL	ACE ROAD		
CARILLO	N ASSISTED LIVING OF	MINT HILL MATTHEN	VS, NC 28105			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 375	Continued From page	e 40	D 375			
		self-administer the ent #2 on 01/18/19 at 4:10pm				
	kept on the medication					
	her room and the stat	to leave the medication in ff did. The ff did is the first the fi				
	the medication to kee	<u> </u>				
	Flonase and the Albuterol inhaler as orderedShe last used the Albuterol inhaler in December					
	2018 sometime befor -She used the Albute fall and spring.	e Christmas. rol inhaler more during the				
		for staff to bring my inhaler.				
	Interview with the MA revealed:	on 10/8/19 at 4:17pm				
	-She was aware that Flonase in her room, the Albuterol inhaler i	but she was not aware of				
	-She did not know if F	Resident #2 had an order to need to ne				
	medications at bedsic -The MA was trained the resident's room if	to remove medications from				
		upset" when you try to				
	-She reported Reside her room to the Reside	ent #2 had the medications in dent Care Director (RCD) but				
	incident.	hen she reported the				
	from the room, but so	o remove the medications omehow the medications				
	always end back in R	esident #2 s 100m. are which staff member kent				

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giving Resident #2's medications from the med

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL060153	B. WING		01	/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAPILLO	N ASSISTED LIVING OF	MINT HILL	RGARET WALL	ACE ROAD		
CARILLO	N ASSISTED LIVING OF	MATTHEY	VS, NC 28105			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 375	Continued From page	e 41	D 375			
	cart.					
	revealed: -She was not aware to medications in her rown in her row	om. Resident #2 she could not her bedside. sible for removing any the residents' rooms. hat a resident could have a diside if there was a physician				
	-When a resident ver self-administer medic initiated before this re -The RCD or designe assessment of the re- capacity to self-admir -The RCD or designe capable of verbalizing purpose of each med assessment is compli- -If the resident is dee	eations steps must be equest is granted. ee will perform an sident's mental and physical nister medications. ee must verify the resident is go the correct dose and ications before the ete.				
	physician stating the medicationsIf the resident is to k room, the order must medications at bedsic -The RCD or designe assessment of the reself-administer at lead document the resider process in the LHPS -The quarterly review	resident may self-administer eep the medications in their also state "OK to keep de." ee will perform continued sident's ability to st quarterly, and will nt's compliance with this				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	DF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:	A. BUILDING:		LETED
		HAL060153	B. WING		01/	08/2019
NAME OF P	ROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, STA	TE, ZIP CODE		
CARILLO	N ASSISTED LIVING OF	MINIT LIII 1 5601	MARGARET WALL	ACE ROAD		
CARILLO	N ASSISTED LIVING OF	MAT	THEWS, NC 28105			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	the dose and purposed-If issues are identified obtain an order to distance administration. The RCD or designer assessment completed designee's assessment self-administration with obtained as relevant. When residents self-medication is to be with medication administration administration administration with the resident self-administer writted and ose has been self-administer with the Heat (HWD) on 01/08/19 at 19. She was not aware to self-administered medication administered medication administered medication administered medication and albutero	es to have a knowledge of e of each medication. Id, the RCD or designee will continue self- e will be notified and an ed. Based on the RCD or ent, the orders to discontinue II continue or new orders administer medications, the ritten on the resident's ation record and the words en on the MAR each it is een self-administered. alth Wellness Director to 1:50pm revealed: of any residents who dications. that Resident #2 had II inhaler in her room.				
	administrationShe needed to speal evaluate Resident #2 self-administer her ov Attempted interview v on 01/08/19 at 12:05p Interview with the Adr 12:25pm revealed: -She was not aware t medications in her rod-The RCD and the HV medications from Residual to the RCD was in the	with Resident #2's physician om was unsuccessful. ministrator on 01/08/18 at hat Resident #2 had om. ND had removed several sident #2's room last week				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	HAL060153		B. WING		01	/08/2019	
ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
N ASSISTED LIVING OF	MINT HILL			ACE ROAD			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FU		ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETE DATE	
Flonase and Albutero -Resident #2 had nev self-administer any m -There were no resid	ol. ver been evaluated to nedications. ents in the facility that		D 375				
G.S. 131D-21 Decla Every resident shall h 4. To be free of ment	ration of Residents' Rig nave the following rights al and physical abuse,	hts	D914				
Based on observation reviews, the facility faresidents were free o	ns, interviews and recor alled to ensure that the if neglect related to pers						
interviews, the facility according to the resic plan, and current syn residents with a histo and #5). [Refer to Tag	r failed to provide super dent's assessed needs, nptoms for 3 of 3 samplory of falls (Resident #3, g 270 10A NCAC 13F	care ed #4,					
	ROVIDER OR SUPPLIER N ASSISTED LIVING OF SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page Flonase and Albutere -Resident #2 had new self-administer any m -There were no resid self-administered me G.S. 131D-21(4) Dec G.S. 131D-21 Decla Every resident shall h 4. To be free of ment neglect, and exploita This Rule is not met Based on observation reviews, the facility for residents were free of care and supervision The findings are: Based on observation interviews, the facility according to the resid plan, and current syn residents with a histo and #5). [Refer to Tag .0901(b) Personal Ca	ROVIDER OR SUPPLIER N ASSISTED LIVING OF MINT HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUR REGULATORY OR LSC IDENTIFYING INFORMATI Continued From page 43 Flonase and AlbuterolResident #2 had never been evaluated to self-administer any medicationsThere were no residents in the facility that self-administered medications. G.S. 131D-21(4) Declaration of Residents' Rig Every resident shall have the following rights 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and recorreviews, the facility failed to ensure that the residents were free of neglect related to persoare and supervision. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide super according to the resident's assessed needs, plan, and current symptoms for 3 of 3 sampl residents with a history of falls (Resident #3, and #5). [Refer to Tag 270 10A NCAC 13F. 0901(b) Personal Care and Supervision (Ty	ROVIDER OR SUPPLIER N ASSISTED LIVING OF MINT HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 43 Flonase and Albuterol. -Resident #2 had never been evaluated to self-administer any medications. -There were no residents in the facility that self-administered medications. G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that the residents were free of neglect related to personal care and supervision. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 3 of 3 sampled residents with a history of falls (Resident #3, #4, and #5). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1	ROVIDER OR SUPPLIER RASSISTED LIVING OF MINT HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 43 Flonase and Albuterol. -Resident #2 had never been evaluated to self-administer any medications. -There were no residents in the facility that self-administered medications. G.S. 131D-21 (4) Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that the residents were free of neglect related to personal care and supervision. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 3 of 3 sampled residents with a history of falls (Resident #3, #4, and #5). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5601 MARGARET WALLACE ROAD MATTHEWS, NC. 28105 SUMMARY STATEMENT OF DEFICIENCIES GEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 43 Flonase and Albuterol. -Resident #2 had never been evaluated to self-administer any medications. -There were no residents in the facility that self-administered medications. G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that the residents were free of neglect related to personal care and supervision. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 3 of 3 sampled residents with a history of falls (Resident #3, #4, and #5). (Refer to Tag 270 10A NCAC 13F, .0901(b) Personal Care and Supervision (Type A1	ROVIDER OR SUPPLIER RADIODISS ROVIDER OR SUPPLIER NASSISTED LIVING OF MINT HILL SUMMARY STATEMENT OF DEFICIENCES (EACH DEPTICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 43 Flonase and Albuterol. -Resident #2 had never been evaluated to self-administer any medications. There were no residents in the facility that self-administered medications. G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that the residents were free of neglect related to personal care and supervision. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the residents were from the residents were free of late (Resident #3, #4, and #5). [Refer to Tag 270 10A NCAC 13F] JOHN DEPTICATION OF THE APPROPRIATE COME. A BUILDING: B. WING D. PROVIDERS PLAN OF CORE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFINITION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFINITION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION THE APPROPRIATE DEFINITION OF THE APPROPRIATE DEFINITION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION THE APPROPRIATE DEFINITION OF THE APPROP	

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