STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CARILLON ASSISTED LIVING OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Wake County Human Services conducted a follow-up survey on April 8 - 10, 2019.	{D 000}		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure that 1 of 5 sampled residents (#1) was treated with respect, consideration and dignity, related to an inappropriate admission to the special care unit of the facility. The findings are: Review of the current FL-2 for Resident #1 was dated 04/09/19 revealed: -Diagnoses included cognitive impairment, essential hypertension, anxiety, depression, generalized weakness, and coronary artery	D 338		

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disease with pacemaker.
-The current level of care marked was other (Secured).
-The requested level of care marked was other (Secured until recommendation from neurology referral).
-Resident #1 was intermittently disoriented.
-There was no diagnosis of Alzheimer or related dementia listed on the FL-2 for Resident #1.

Review of Resident #1's progress notes dated 03/20/19 revealed she was transferred to the special care unit per doctor's order related to increased need for monitoring due to wandering and increased confusion.

Reviewed of Resident #1's physician orders dated 03/20/19 revealed:
-An order to "please place patient in secured memory unit".
-There was no reason given for the transfer to the SCU.

Interview with Resident #1 on 04/09/19 at 4:53 p.m. revealed:
-"They put me back here because I went outside without permission."
-Her daughter told her if she went outside without permission they were going to lock her up and that was what they did.
-"I don't belong back here".
-"I like the cafeteria much better".
-"My daughter knows I don't belong back here".
-Her daughter was working on trying to get her out of there.
-She would need to see a neurologist first, her daughter was going to make the appointment and take her.
-"They are going to ask me a bunch of stupid questions like what's my name, when was I born

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and where I live".
-She went to a neurologist years ago when she had some weakness on her left side.
-"In the meantime" they put her back there and she "have to eat with people less fortunate than myself".
-"I miss talking to my friends."

Attempted telephone interview with Resident #1's POA on 04/10/19 at 4:00 p.m. was unsuccessful.

-Review of Resident #1's Report of Health Services to Resident revealed:
-A physician's order dated 03/19/19 to collect urine for a urine analysis due to altered mental status (AMS) and increased confusion.
-A physician's order dated 04/02/19 to please start to evaluate resident per protocol for potential return to Assisted Living (AL) due to the results of the cognitive assessment.

Interview with Resident #1's primary care physician (PCP) on 04/10/19 at 1:31 p.m. revealed:
-She wrote the order to place Resident #1 in the SCU at the request of the facility for her safety due to increased confusion.
-Resident #1 was treated for a urinary tract infection (UTI).
-Resident #1 was reassessed after treatment for UTI and an order was written to evaluate her for return to AL.
-She was told by the facility that their policy was to administer a brief cognitive test, consult with the facility's corporate office and request a neurology consult before the resident could be returned to AL.
-She had never had this situation before for acute AMS.
-With acute AMS, "we wait until infection is

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resolved before the resident is moved somewhere else".
-She discussed with Resident #1's POA about the resident's move to the SCU and she understood the reason for the move for the resident's safety.
-Resident #1's POA was of the understanding that once the resident's infection was treated and resolved that Resident #1 would be returned to AL.
-She spoke with Resident #1's POA last week concerning the results of the cognitive test she administered to Resident #1 and her recommendation for resident to be moved back to the AL unit.
-She also discussed with Resident #1's POA concerning the facility's added requests prior to resident being moved back to the AL unit.
-She wrote an order for a neurology referral for Resident #1 for further cognitive workup per the facility's request.

Interview of the SCU Resident Care Coordinator (RCC) on 04/10/19 at 12:42 p.m. revealed:
-Resident #1's PCP did administer a cognitive assessment to resident.
-She was told by the PCP that Resident #1 scored okay, she did not give me the specifics of the results.
-She thought that Resident #1 would be moved back to the AL unit.
-Resident #1 mentioned to her about going to visit her friends on the AL unit, participating in some of the activities and talking with her friends.
-She had noticed that Resident #1 got upset sometimes.
-Resident #1's POA had inquired about moving her back to the AL unit after resident was treated for her UTI and her infection was resolved.
-In daily morning meeting last week, she could not recall day or date, it was mentioned about

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D 338	Continued From page 4 having a room ready for Resident #1 on the AL unit. Interview with the Executive Director (ED on 04/10/19 at 9:10 a.m. revealed: -The facility was working with Resident #1's PCP to have resident assessed by a neurologist. -The referral for the Neurologist was ordered by Resident #1's PCP on 04/09/19. -He would work to have the issue concerning Resident #1's placement in the appropriate unit resolved as soon as possible. The facility provided a plan of protection in accordance with G.S 131D-34 on 5/14/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 25, 2019.	D 338		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	{D 358}		

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{D 358}	Continued From page 5 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 5 residents (#6) observed during the medication passes including errors with an anti-arrhythmic medication, anti-hypertensive, anti-depressant, vitamin supplements, and eye drops; and for 1 of 5 residents (#5) sampled for record review including errors with a medication used to treat Alzheimer's dementia. The findings are: 1. The medication error rate was 20% as evidenced by the observation of 6 errors out of 29 opportunities during the 8:00am and 9:00am medication passes on 04/09/19 and 12:00pm medication passes on 04/10/19. Review of Resident #6's current FL-2 dated 01/08/19 revealed diagnoses included dementia, anxiety disorder, hypothyroidism, arrhythmia, major depressive disorder, and other dysphagia. a. Review of a signed physician's order sheet for Resident #6 dated 01/08/19 revealed: -There was an order for Zoloft 50mg once daily (Zoloft is used to treat major depressive disorder). -There was an order for Multivitamin 1 tablet once daily (Multivitamin is a vitamin supplement). -There was an order for Vitamin D3 1000 units daily (Vitamin D3 is a vitamin supplement). -There was an order for Flecainide 50 milligrams	{D 358}		

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(mg) every 12 hours (Flecainide is used to treat abnormal heart rhythms).
-There was an order for Levothyroxine 100 micrograms (mcg) every morning (Levothyroxine is used to treat the thyroid).
-There was an order for Metoprolol Tartrate 12.5 twice a day (Metoprolol is a medication used to treat high blood pressure and prevent heart attacks).

Review of Resident #6's physician's standing orders dated 12/26/19 revealed there was a check beside "Oral medications may be crushed and/or placed in applesauce, pudding, or juice if not contraindicated by pharmacy. Refer to Do Not Crush list. Do not crush "Time Released" medication".

Observation of the 8:00 am medication pass on 04/09/19 revealed:
-The medication aide (MA) placed a Vitamin D3 gel capsule, Flecainide, Levothyroxine, Metoprolol, and Multivitamin in a clear pill crush pouch and crushed the gel capsule and the four other tablets together.
-The MA poured the medications from the pill crush pouch into a plastic medication cup.
-There were blue, white, yellow, and orange pill fragments adhering to the gel residue on the inside walls and bottom of the pill crush pouch.
-The MA did not attempt to remove the pill fragments left inside the pill crush pouch.
-The MA discarded the pill crush pouch containing the pill fragments and gel residue in the trash.
-The MA mixed applesauce with the medications in the plastic medication cup and administered to Resident #6.

Review of Resident #6's April 2019 electronic

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medication administration record (eMAR) revealed
-There was an entry for daily Multiple Vitamins one tablet once daily with documentation of administration at 8:00 am from 04/01/19 - 04/09/19.
-There was an entry for Flecainide 50mg every 12 hours with documentation of administration at 8:00 am and 8:00 pm from 04/01/19 - 04/08/19, and on 04/09/19 at 8:00 am.
-There was an entry for Metoprolol 12.5mg twice a day and documented as administered at 8:00 am and 8:00 pm from 04/01/19 - 04/08/19, and at 8:00 am on 04/09/19.
-There was an entry for Zoloft 50mg once daily and was documented as administered at 8:00 am from 04/01/19 - 04/09/19.
-There was an entry for Vitamin D3 1000 unit 1 tablet once daily and was documented as administered at 8:00 am from 04/01/19 - 04/09/19.
-There was no documentation on the eMAR about crushing Resident #6's medications.

Observations of Resident #6's medications on hand on 04/09/19 revealed none of the medications were labeled as do not crush.

Interview with the MA on 04/09/19 at 9:14 am revealed:
-She normally crushed the Vitamin D3 gel capsule with other tablets for Resident #6 because Resident #6 had difficulty swallowing the medication.
-The eMAR would usually flag any medications that could not be crushed.

A second interview with the MA on 04/09/19 at 12:55pm revealed:
-She had been trained by a former MA, when she

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first started about five months ago, to crush all medications for Resident #6.
-She had only worked in the special care unit (SCU) for one month.
-She had only worked three times as a MA in the SCU.
-After crushing Resident #6's medications there would normally be residue and pill fragments left in the pill crush packet because the pill fragments would stick to the gel in the pouch from the gel capsule.
-She had never scraped the inside of the pill crush pouch to get all the medication fragments after crushing medications.
-The medication left in the pill crush pouch was fragments and residue and was not supposed to be administered to residents because they would have difficulty swallowing the fragments and residue.
-There was not a "Do Not Crush" medication list on the medication cart.
-She did not know where the "Do Not Crush" medication list was kept.
-She had never seen a "Do Not Crush" medication list at the facility.
-The eMAR in the SCU did not flag medications that were not supposed to be crushed.

Interview with a second MA on 04/09/19 at 1:27 pm revealed:
-Resident #6 could take medications whole in applesauce, but she would have to administer the medications slow because Resident #6 would spit out the pills.
-She had sometimes crushed Resident #6's medications for administration.
-Gel capsules could not be crushed because the gel would be difficult to get out of the pill crush pouch.
-She would administer gel capsules whole in

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applesauce.
-The eMAR would not always note if a medication was to be crushed.
-If the eMAR did not note to crush a medication, and the resident spit out the medication, she would make the determination to crush the resident's medications.
-There was supposed to be a "Do Not Crush" list in the SCU, but she did not know if there was one.
-There was a "Do Not Crush" list on the A Hall medication cart.

Interview with the Resident Care Coordinator (RCC) on 04/09/19 at 1:47 pm revealed:
-If residents had difficulty swallowing medications the medications would be crushed.
-There was a "Do Not Crush" list kept on the medication carts for MAs to reference.
-Sometimes the eMAR would note to crush or not to crush a medication.
-If the eMAR did not note to crush a medications, the MAs would check the "Do Not Crush" list.
-Gel capsules were not to be crushed, but put whole in applesauce to administer to the residents.
-All crushed medications would freely come out of the pill crush pouch.
-If all the medication did not freely come out of the pill crush pouch, she expected the MAs to take a spoon and scrape out all of the medication for administration.
-The MA's were trained on crushing medications when they were trained on the medication cart.
-All MA's had been trained to work in the SCU and the Assisted Living (AL).

Interview with the Resident Care Director (RCD) on 04/09/19 at 2:30 pm revealed:
-The MA should not have crushed Resident #6's

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{D 358}	Continued From page 10 gel capsule. -The MAs were trained about crushing medications and observed during their medication pass before working on the medication cart by a Registered Nurse (RN). -Gel capsules could not be crushed because crushing them would affect the medication absorption. -She expected any medication left in a pill crush pouch to be scraped out for administration to the resident. -The eMAR did not note to crush medications. -The facility had a "Do Not Crush" medication list but she did not know where it was kept. -She did not know if the MAs knew where the "Do Not Crush" medication list was kept. Telephone interview with the Primary Care Provider (PCP) for Resident #6 on 04/09/19 at 4:45 pm revealed: -She expected all of Resident #6's medications to be administered. -She was concerned Resident #6 could have an increase in heart rate or arrhythmias from not receiving a full dose of the Flecainide. -She was concerned Resident #6 could have an increase in blood pressure from not receiving a full dose of the Metoprolol. -She was concerned Resident #6 would exhibit withdrawal symptoms of suicidal ideation, agitation, and anxiety from not receiving all of the Zoloft. -She was not as concerned about Resident #6 not receiving all of the Zoloft as she was the Flecainide and Metoprolol because Resident #6 was still getting some of the Zoloft. Based on observation, record review, and interview it was determined Resident #6 was not interviewable.	{D 358}		

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{D 358}	Continued From page 11 b. Review of an electronically signed physician's order for Resident #6 dated 03/27/19 revealed there was an order for Visine 0.05% instill one drop in each eye two times daily (Visine is an eye drop used to treat eye redness and itching). Observation of the 8:00 am medication pass on 04/09/19 revealed: -Resident #6 was sitting up in a chair in the Special Care Unit (SCU) common area with her head tilted back. -The MA was standing over Resident #6 attempting pull to up on Resident #6's left upper eye lid. -Resident #6 was trying to close her eyes. -The MA was holding the eye medication bottle over the top of Resident #6's left eye. -The eye drop landed on top of Resident #6's left eye lashes and rolled across the top of the lashes towards the inner part of her eye, and along the inner part of the bridge of her nose. -The medication did not go into Resident #6's left eye. -With a tissue, the MA wiped the drop from just below Resident #6's eye beside the inner bridge of her nose. -One eye drop was administered in Resident #6's right eye. Review of Resident #6's April 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Visine 0.05% instill one drop in each eye twice daily with scheduled administration times of 8:00 am and 8:00 pm. -Visine was documented as administered from 04/01/19 - 04/08/19 at 8:00 am and 8:00 pm, and on 04/09/19 at 8:00 am.	{D 358}		

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{D 358}	Continued From page 12 Interview with the MA on 04/09/19 at 12:55 pm revealed: -She thought she had administered another drop when the first drop did not go into Resident #6's eye. -She was trained and observed by a Registered Nurse (RN) on administering eye drops when she first started working at the facility five months ago. -She would have the residents sit down and lean their head back, then she pulled up on the upper eye lid and down on the lower eye lid when the residents try to close their eyes. -She never had problems administering eye drops in resident's eyes when they were sitting down. -If she had problems administering eye drops in resident's eyes when sitting, she would have them lay down. Interview with the Resident Care Coordinator (RCC) on 04/09/19 at 1:47 pm revealed: -The MAs had received hands on training with administration of eye drops when trained on the medication carts. -The MAs were expected to pull down the resident's lower eye lid to make a pocket for administration of eye drops in the lower eye lid. -The residents would either sit or lay down for the eye drop administration. -If the MA had difficulty administering the eye drops with the resident sitting up, it was expected to have the resident lay down for eye drop administration. Interview with the Resident Care Director (RCD) on 04/09/19 at 2:30 pm revealed: -The MAs should have been trained by the Registered Nurse (RN) for eye drop administration techniques.	{D 358}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 13 -The residents were to sit down and tilt their head back for eye drop administration. -If the MAs had difficulty administering the eye drops when the residents were sitting down, the residents should be asked to lay down for eye drop administration. -The MAs were to pull down on the resident's lower eye lid to make a pocket and administer the eye drops in the pocket that was created. Telephone interview with Resident #6's Primary Care Provider (PCP) on 04/09/19 at 4:45 pm revealed: -She expected Resident #6's eye drops to be administered as ordered. -Resident #6 could have dry eyes that would cause her discomfort and pain if she did not have the eye drops administered as ordered. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. 2. Review of Resident #5's current FL-2 dated 05/15/18 revealed: -Diagnoses included dementia, diabetes mellitus type 2, rheumatoid arthritis, hypothyroidism, and gait instability. -There was an order for Aricept 10mg 1 tablet once daily. (Aricept is used to treat dementia related to Alzheimer's disease. According to the manufacturer, Aricept should be taken in the evening.) Review of Resident #5's subsequent physician's orders sheet dated 08/24/18 and 03/26/19 revealed orders for Aricept 10mg 1 tablet every evening. Review of Resident #5's February 2019 - April	{D 358}		

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{D 358}	Continued From page 14 2019 electronic medication administration records (eMARs) revealed: -There was an entry for Aricept 10mg take 1 tablet every evening but it was scheduled for administration at 9:00am. -Aricept was documented as administered every day at 9:00am from 02/01/19 - 04/09/19 instead of in the evening as ordered. Observation of Resident #5's medications on hand on 04/10/19 at 1:10pm revealed there was a supply of Aricept 10mg dispensed on 03/05/19 with instructions to take 1 tablet every evening. Interview with Resident #5 on 04/10/19 at 12:59pm revealed the resident knew she took medications but she could not recall which medications or what time she received them. Interview with Resident Care Coordinator / Medication Aide (RCC/MA) on 04/10/19 at 2:10pm revealed: -She routinely helped with administering medications to the residents. -She had not noticed the instructions on the eMAR and the medication label for Aricept were to administer the medication in the evening. -She usually administered the Aricept in the morning because that was when the Aricept "popped" on the eMAR to be administered. -The instructions on the eMAR were visible when the Aricept "popped" up to be administered in the mornings but she had not noticed the discrepancy. Telephone interview with Resident #5's primary care provider (PCP) on 04/10/19 at 1:40pm revealed: -Resident #5's Aricept should be administered in the evening as ordered.	{D 358}		

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{D 358}	Continued From page 15 -She was not aware it was being administered at 9:00am. -She did not have any immediate concerns about the resident receiving Aricept in the morning but it should be administered in the evenings. Interview with the RCC and the Resident Care Director (RCD) on 04/10/19 at 5:30pm revealed: -They were responsible for faxing orders to the pharmacy. -The pharmacy usually entered medications orders in the eMAR system. -The RCC and RCD reviewed and approved the orders in the eMAR system, including instructions and administration times. -They did not notice Resident #5's Aricept was scheduled and administered at 9:00am instead of in the evening as ordered. -The MAs were trained to read the eMARs and medication labels prior to administering medications. -If something did not match on the eMARs and labels, the MAs were supposed to notify the RCC or RCD. -No one had notified the RCC or RCD of the discrepancy with the administration time for Resident #5's Aricept. -They would correct Resident #5's Aricept entry on the eMAR.	{D 358}		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for	D 463		

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D 463	Continued From page 16 admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure that 2 of 2 sampled residents (#1 and #7) admitted to the Special Care Unit (SCU) had a diagnosis that met the conditions of the specific group of residents in the SCU and documentation of a pre-admission screening by the facility evaluating the appropriateness of Residents #1 and Resident #7's placement in the SCU. The findings are: Review of the Special Care Unit Disclosure Statement revealed: -For admission to the SCU, each individual must meet the admission criteria of having a diagnosis of Alzheimer's or related dementia on the FL-2. -Prior to admission, an assessment, a brief cognitive rating system evaluation is done on each individual to determine the ability of the facility to meet their needs and the	D 463		

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appropriateness of the resident's placement in the SCU.
-Prior to admission, a physician shall specify an appropriate Alzheimer's diagnosis on the resident's FL-2 that meets the condition of the specific group of residents to be served in the Special Care Unit.
-The admission of a resident to the SCU will include a pre-admission assessment and interview with the family and resident.

1. Review of Resident #1's previous FL-2 dated 03/22/19 revealed:
-Diagnoses included generalized weakness, essential hypertension benign, anxiety, depression, cognitive impairment, coronary artery disease with duel chamber pacemaker.
-Recommended level of care marked for Resident #1 was other (Assisted Living Facility, Secure Care Unit written in the space next to other).
-Resident #1 was constantly disoriented and a wanderer.
-There was no diagnosis of Alzheimer or related dementia listed on Resident #1's FL-2.

Review of the current FL-2 for Resident #1 was dated 04/09/19 revealed:
-Diagnoses included cognitive impairment, essential hypertension, anxiety, depression, generalized weakness, and coronary artery disease with pacemaker.
-The current level of care marked was other (Secured).
-The requested level of care marked was other (Secured until recommendation from neurology referral).
-Resident #1 was intermittently disoriented.
-There was no diagnosis of Alzheimer or related dementia listed on this FL-2 for Resident #1.

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D 463	Continued From page 18 Review of Resident #1's Resident Register dated 04/09/19 revealed she was admitted to the facility on 02/11/19. Review of Resident #1's records revealed there was no pre-admission screening documentation specific to the SCU completed for admission to the SCU. Review of Resident #1's progress notes dated 03/20/19 revealed that she was transferred to the SCU per doctor's order related to increased need for monitoring due to wandering and increased confusion. Reviewed of Resident #1's physician orders dated 03/20/19 revealed: -An order to please place patient in secured memory unit. -There was no reason given for the transfer to the SCU. Interview with the Assisted Living (AL) Resident Care Coordinator (RCC) on 04/09/19 at 12:36 p.m revealed Resident #1 was placed in the SCU for safety due to episodes of confusion. Interview with the SCU Resident Care Coordinator (RCC) on 04/10/19 at 12:42 p.m revealed Resident #1 was admitted to the SCU for her safety. Interview with the Resident Care Director (RCD)/ Licensed Practical Nurse (LPN) on 04/09/19 at 12:06 p.m revealed: -Resident #1 was admitted to the SCU for safety and because the resident required more assistance with ADLs. -She did not recall having done a SCU	D 463		

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pre-admission assessment for Resident #1 prior to her admission to the SCU.

Interview with the Executive Director (ED on 04/10/19 at 9:10 a.m. revealed:
-Resident #1 was admitted to the SCU for her safety.
-He would look into the need for increased supervision for Resident #1 and Resident #1 on the AL unit.

Refer to interview with the Assisted Living (AL) RCC on 04/09/19 at 12:36 p.m.

Refer to interview with the SCU RCC on 04/10/19 at 12:42 p.m.

Refer to interview with the RCD/ Licensed Practical Nurse (LPN) on 04/09/19 at 12:06 p.m.

Refer to interview with the Executive Director (ED) on 04/10/19 at 9:10 a.m.

2. Review of Resident #7's previous FL-2 dated 03/13/19 revealed:
-Diagnoses included hepatic cyst/ mass, right flank pain, hemorrhagic mass, hem peritoneum, hypertension and hypothyroidism.
-Recommended level of care marked for Resident #7 was Domiciliary (Rest Home).
-Next to the word hospital was written memory care and written below and to the right of the word memory care, the word error was written.
-Resident #7 was intermittently disoriented.
-There was no diagnosis of Alzheimer or related dementia listed on Resident #7's FL-2.

Review of the current FL-2 for Resident #7 was dated 04/10/19 revealed diagnoses included dementia unspecified, muscle weakness,

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aphasia, dysphasia, hypothyroidism and abnormalities of gait and mobility.

Review of Resident #7's Resident Register revealed there was no admission date.

Review of Resident #7's progress notes dated 03/13/19 revealed the resident was re-admitted to the facility and admitted to the SCU on 03/13/19.

Review of Resident #7's Personal Care Physician Authorization and Care Plan dated 03/20/19 revealed:
-A reassessment was performed for Resident #7 on 03/14/19 due to significant change.
-Written below significant change were the words secure unit.
-Resident #7's most recent examination by her primary care physician was 03/13/19.
-Next to the words social/mental health history was written that Resident #7 lives in the Alzheimer's Unit due to confusion and for her safety.
-For orientation was marked as sometimes disoriented.

Review of Resident #7's records revealed there was no pre-admission screening documentation specific to the SCU completed for admission to the SCU.

Interview with the Assisted Living (AL) Resident Care Coordinator (RCC) on 04/09/19 at 12:36 p.m revealed Resident #7 was placed in the SCU for safety due to epesodes of confusion.

Interview with the SCU Resident Care Coordinator (RCC) on 04/10/19 at 12:42 p.m. revealed Resident #7 was admitted to the SCU for her safety and she required more assistance

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D 463	Continued From page 21 than normal with her ADLs. Interview with the Resident Care Director (RCD)/ Licensed Practical Nurse (LPN) on 04/09/19 at 12:06 p.m revealed: -Resident #7 was admitted to the SCU for safety and because she required more assistance with ADLs. -She did not recall having done a SCU pre-admission assessment for Resident #7 prior to admission to the SCU. Interview with the Executive Director (ED on 04/10/19 at 9:10 a.m. revealed: -Resident #7 was admitted to the SCU for her safety. -He would look into the need for increased supervision for Resident #7 on the AL unit. Refer to interview with the Assisted Living (AL) Resident Care Coordinator (RCC) on 04/09/19 at 12:36 p.m. Refer to interview with the SCU Resident Care Coordinator (RCC) on 04/10/19 at 12:42 p.m. Refer to interview with the Resident Care Director (RCD)/ Licensed Practical Nurse (LPN) on 04/09/19 at 12:06 p.m. Refer to interview with the Executive Director (ED) on 04/10/19 at 9:10 a.m. Interview with the AL RCC on 04/09/19 at 12:36 p.m. revealed: -A physician order was required to place a resident in the SCU for safety. -The physician came to the facility within 24 hours after the order was written to do a routine check. -When residents came to the SCU their	D 463		

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D 463	Continued From page 22 paperwork had already been processed. -The Resident Care Director (RCD)/ Licensed Practical Nurse (LPN) and the Executive Director (ED)/Administrator did the paperwork for residents admitted to the SCU. Interview with the SCU Resident Care Coordinator (RCC) on 04/10/19 at 12:42 p.m. revealed: -She started work at the facility 02/18/19. -She did not complete the SCU pre-admission assessments. -The RCD/ LPN or the AL RCC did the pre-admission assessments to see if the resident met the criteria to be admitted to the SCU. Interview with the RCD/LPN on 04/09/19 at 12:06 p.m. revealed: -In the SCU, residents usually have Alzheimer, dementia or they required more assistance with activities of daily living (ADLs). -She started working at the facility 02/18/19. -She was not aware that residents were required to have a diagnosis of Alzheimer, dementia on their FL-2 to be admitted to the SCU. Interview with the ED on 04/10/19 at 9:10 a.m. revealed: -He had been the ED for a week and a half. -He had never worked as an ED before so he was still learning. -He was not aware residents required a diagnosis of Alzheimer or dementia listed on their FL-2 prior to admission to the SCU or that SCU pre-admission was required.	D 463		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights	D911		

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D911	Continued From page 23 Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure all residents were treated with respect, dignity and consideration as relates to Resident's Rights. The findings are: Based on observations, interviews and record reviews, the facility failed to ensure that 1 of 5 sampled residents (#1) was treated with respect, consideration and dignity, related to an inappropriate admission to the special care unit of the facility. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D911		