STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 Department of Social Service conducted an annual and follow-up survey from 01/13/20 - 01/16/20.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure the facility was free of hazards as evidenced by storage of multiple portable oxygen (O2) cylinders in an unsafe manner, on the floor not secured in racks or crates, in 2 residents' rooms and transporting by propping in resident rollators while in use. The findings are: Observation of Hall A room 2 on 01/14/20 at 11:15am revealed: -There were three portable O2 cylinders in the resident's room. -One of the cylinders did not have plastic seal and was standing upright on the floor beside an O2	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 079	Continued From page 1	D 079		

concentrator.
-One of the cylinders had an O2 valve attached and was standing upright on the floor against the front of an arm chair beside a side table.
-One of the cylinders was in a cloth portable bag with a shoulder strap and was propped up in the seat of the resident's rollator in front of the resident.
-The resident was sitting in a chair located in front of the O2 cylinders and receiving O2 from an O2 concentrator.
-There was not an O2 storage rack in the room.

Interview with the resident who resided in room 2 on hall A on 01/14/20 at 11:15am revealed:
-The resident used the portable O2 cylinders when out of the room.
-The resident would push the rollator with the O2 cylinder propped in the seat of the rollator.
-The resident did not know how long the O2 cylinders had been in the room.

Observation of the Resident Care Director (RCD) on 01/14/20 at 11:17am revealed she picked up both cylinders and stood them upright on the floor in the resident's closet located outside the resident's room.

Interview with the RCD on 01/14/20 at 11:17am revealed:
-She knew the resident did not have an O2 cylinder storage rack.
-The resident had never had an O2 cylinder storage rack for the small O2 cylinders.
-The durable medical equipment (DME) company representative would place the portable O2 cylinders in the resident's room unsecured.
-She would contact the DME company to bring an O2 storage rack for the resident.
-She would store the O2 cylinders in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 079	Continued From page 2	D 079		

resident's closet until the DME company could deliver a storage rack.
-She thought there was an O2 storage rack in a staff room by the employee lounge.
-The O2 storage rack in the staff room was used to store the facility's emergency O2 cylinders.

Observation of the RCD on 01/14/20 at 11:25am revealed she removed the O2 cylinders from the resident's closet and placed them in an O2 storage rack in a staff room by the employee lounge.

Interview with a medication aide (MA) on 01/16/20 at 8:06am revealed:
-The resident had a portable O2 shoulder bag to transport the O2 cylinder when ambulatory but would not wear it.
-The resident would prop the portable O2 cylinder in the seat of a rollator and walk with the rollator.
-The residents O2 cylinders were stored in the resident's room.
-She placed portable O2 cylinders unsecured in the resident's room in December 2019.
-The resident did not have an O2 storage rack in the room.
-The residents portable O2 cylinder was draped across the back of a chair in the dining room in December 2019.
-The O2 cylinder fell and landed on the MA's toe.
-She picked up the O2 cylinder from the floor and hung it on the back of the chair.
-Staff would hang the O2 cylinder on the back of the resident's chair when in the dining room.
-There was another resident in the secured care unit (SCU) who had O2 cylinders stored in the resident's closet.

Observation of the SCU dining room at 8:30am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 079	Continued From page 3	D 079		

-There was resident sitting at the dining table using0 portable O2.
-There was a rollator beside the resident.
-There was a portable O2 cylinder in a black cloth carrier propped in the seat of the rollator leaning at an angle towards the corner of the handles.

Observation of SCU room C6 on 01/16/20 at 8:31am revealed:
-There were nineteen portable O2 cylinders in the resident's closet.
-Ten of the O2 cylinders did not have bands around the top of the cylinders.
-Nine of the O2 cylinders did have bands around the top of the cylinders.
-One of the O2 cylinders without bands was not secured in a rack and was standing upright in the closet.

A second interview with the MA on 01/16/20 at 8:50am revealed:
-She had never been educated on how to store O2.
-The resident in the SCU dining room with the portable O2 tank always walked with the portable O2 tank propped on the rollator.
-She did not know if the O2 cylinder for the resident in the SCU dining room had ever fallen.

Interview with a personal care aide (PCA) on 01/16/20 at 8:59am revealed:
-The residents O2 cylinders were stored in the resident's closet in the SCU.
-She had never been educated on how to store O2 cylinders.
-The SCU resident always walked with the portable O2 cylinder propped in the seat of the rollator.
-Staff would prop the residents portable O2 cylinder in the seat of the rollator for the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 079	Continued From page 4 Interview with the Memory Care Director (MCD) on 01/16/20 at 9:00am revealed: -The resident pushing the rollator with the O2 cylinder propped in the rollator had fallen in the past. -She did not remember when he had fallen. -Staff propped the resident's portable O2 cylinder in the resident's rollator while he ambulated with the rollator. -Third shift staff propped the O2 cylinder in the walker for the resident this morning (01/16/20). -She had never seen or been reported to the O2 cylinder had fallen. -She had been educated how to place the O2 cylinder in the portable pouch and prop it in the rollator by a previous Regional Nurse about nine years ago. -The same Regional Nurse educated to store the O2 cylinders in residents' closets. -The O2 cylinder would not move "too much" when propped in the rollator. -The O2 cylinder was not secured to anything when propped in the rollator. -Staff had in-services on O2. -She did not know when the last in-service was provided to staff. -DME would place the resident's O2 cylinders in the resident's closets in SCU. Observation of the resident on 01/16/20 at 9:09am revealed the resident was exiting the dining room pushing a rollator with an O2 cylinder propped in the rollator while receiving O2 from the cylinder. Interview with the Health and Wellness Director (HWD) on 01/16/20 at 9:10am revealed: -About two to three weeks ago an O2 cylinder was propped up at the SCU nursing station	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 079	Continued From page 5	D 079		

unsecured.
-The O2 cylinder fell over at the SCU nursing station.
-The O2 cylinder was picked up and placed in a storage rack.
-O2 cylinders should be transported in a secured rolling O2 device.
-O2 cylinders in shoulder bags are expected to be worn by the resident when mobile.
-O2 cylinders should be stored upright in an approved O2 storage rack in a closet away from sparks because they could "shoot through the building".

Telephone interview with a representative from the O2 DME company on 01/16/20 at 9:30am revealed:
-O2 cylinders should be stored in an O2 rack to prevent from falling over because O2 was a combustible.
-O2 cylinders placed in the O2 cylinder bag should be worn over the shoulder.
-O2 cylinders were not safe to be transported by propping in a rollator because they were not secured and could fall creating a torpedo like device.
-There was a safety concern storing O2 cylinders in SCU resident closets because a resident could pick up the O2 cylinder not realizing what it was.

Interview with the Executive Director on 01/16/20 at 11:00am revealed:
-All O2 cylinders, both full and empty, should be stored upright in an O2 storage rack.
-There was no designated storage area for resident's O2 cylinders other than in their rooms.
-The O2 cylinders placed in the cloth bags were zipped closed and either could be placed on the resident's shoulder or on a walker or rollator.
-The resident in the SCU preferred to prop the O2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 079	Continued From page 6	D 079		

cylinder on the rollator instead of wearing it on his shoulder.
-The resident in the SCU had been "coached" to keep the O2 cylinder secure when walking with the O2 cylinder propped in the seat of the rollator.
-The resident in the SCU would pay attention but was forgetful.
-He had seen staff position the O2 cylinder on the resident's rollator.
-He did not know if the O2 cylinders were secured to the rollator.
-If the O2 cylinder fell the valve stem could break off.
-If the valve stem broke off the O2 cylinder could propel across the room.
-A propelling O2 cylinder would be a safety concern because the cylinder could hit someone.
-The resident in the Assisted Living (AL) side would not wear the shoulder bag.
-Staff were trained how to store and transport O2 by making sure the cylinder was secure so it could not fall off the rollator.
-O2 training took place during orientation and as needed.
-He was concerned about storing O2 cylinders in the SCU where residents could access them because a resident may pick up the O2 cylinder and drop it.

_____

The facility failed to assure residents were free from hazard by allowing residents to transport unsecured O2 cylinders by propping in the seat of rollators that were being pushed by residents while those residents were receiving O2, storing O2 cylinders in an upright position unsecured creating a propelling hazard, and storing nineteen O2 cylinders in a residents closet located in the SCU who was forgetful and easily accessible by other residents with dementia. The facility's failure was detrimental to the health, safety, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 079	Continued From page 7 welfare to the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance to G.S. 131 D-34 on 01/16/20 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 1, 2020.	D 079		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure there was documentation of a two-step tuberculin (TB) skin test for 1 of 7 sampled staff (G) upon hire. The findings are: Review of Staff G's personnel record revealed: -She was hired 12/09/19 as a medication aide (MA). -There was documentation of an outdated TB skin test that was placed 05/04/18 and read as	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 131	Continued From page 8	D 131		

negative on 05/07/18.
-There was no documentation of a more recent TB skin test within 12 months of her date of hire at the facility.

Interview with Business Office Manager (BOM) on 01/15/20 at 4:00pm revealed the Health and Wellness Director was responsible for the TB Skin Testing and trainings for staff.

Interview with the Health and Wellness Director (HWD) on 01/15/20 at 4:19pm revealed:
-The Business Office Manager was responsible for keeping documentation of trainings that facility staff had.
-She was responsible for the TB skin testing of staff members.
-She did not know if Staff G had her two step TB skin test completed because Staff G was hired prior to her being hired at the facility.

Interview with the Executive Director (ED) on 01/15/20 at 4:34 p.m. revealed:
-The BOM and the HWD worked together to make sure staff qualifications are met including TB skin testing.
-The HWD performed the TB skin tests and read them.
-The HWD then gave the completed TB skin tests to the BOM to be placed in the staff personnel record.
-He did not know if Staff G had a two-step TB skin test but he would try to find a more recent TB skin test for her.

No other TB skin test was provided for Staff G by survey exit on 01/16/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 137	Continued From page 9	D 137		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record review and interview the facility failed to access the North Carolina Health Care Personnel Registry (HCPR), document the check and assure staff had no findings listed prior to employment for 2 of 7 staff (Staff A and E). The findings are. 1. Review of the personnel record for Staff A (medication aide) revealed: -A hire dated of 10/18/19 as a personal care aide (PCA). -She became a medication aide (MA) on 12/04/19. -There was no documentation of a HCPR had been checked prior to employment. Refer to interview with the Business Office Manager (BOM) on 01/16/20 at 3:07pm. Refer to interview with the Executive Director (ED) on 01/16/20 at 4:00pm. 2. Review of the personnel record for Staff E (personal care aide) revealed: -A hire date of 03/26/14.	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 137	Continued From page 10 -There was no documentation of a HCPR had been checked prior to employment. Refer to interview with the Business Office Manager (BOM) on 01/16/20 at 3:07pm. Refer to interview with the Executive Director (ED) on 01/16/20 at 4:00pm. _____ Interview with the BOM on 01/16/20 at 3:07pm revealed: -She was responsible for the verifying for all new staff there was no substantiated findings on the North Carolina Health Care Personnel Registry. -On 01/01/20, the facility had a change in management companies, and she was not able to access the previous management company's computer system which stored the staff's personnel paperwork. -She had contacted employees of the previous management company (Vice President and President/Executive Officer) on 01/15/20 and 01/16/20 to obtain the requested paperwork. -She had not received the requested documentation during the survey at the time of exit. Interview with the Executive Director (ED) on 01/16/20 at 4:00pm revealed: -The BOM was responsible for ensuring all new staff had a HCPR check upon hire. -The facility was not able to access the personnel record on the previous management company's computer system. -They had been unable to locate a current or previous HCPR check for Staff A and E. -He was aware the HCPR checks were to be completed upon hire to verify there was no history of alleged abuse.	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 11	D 273		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for 2 of 5 sampled residents (#3, #1) who (#3) sustained an unwitnessed fall, had vomited, and was incontinent of stool who later developed tingling and weakness of his left hand and legs, and a referral for Physical Therapy for gait instability and falls; and a resident (#1) with a referral for Physical and Occupational Therapy. The findings are: 1. Review of Resident #3's current FL-2 dated 09/17/19 revealed: -Diagnoses included hypertension and diabetes. -The resident was ambulatory with a wheelchair. -The resident was incontinent of bladder and bowel. Review of Resident #3's Resident Register dated 08/05/19 revealed an admission date of 08/28/19.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 12 Review of Resident #3's Care Plan dated 09/24/19 revealed: -The resident was oriented. -The resident required limited assistance from staff with toileting, bathing, and dressing. -The resident required a wheelchair for mobility and limited assistance from staff with locomotion/ambulation. a. Observation of Resident #3 on 01/13/20 at 9:55am revealed: -The resident was sitting in a chair located in the corner of his room. -The resident attempted to rub his nose with his left hand. -The resident's left arm and hand would drop down as the resident attempted to raise his left hand to his nose. -The resident took his left hand in his right hand, shook it, and raised it to scratch his nose. Interview with Resident #3 on 01/13/20 at 9:55am revealed: -His left arm and hand were weak. -"Come on hand and work." -He could not walk. -He walked "last night". -He had told the medication aide (MA) who administered his medications this morning that his left arm and hand were weak and numb, and he could not walk. -The MA had not returned since he told her his left arm and hand were weak and he could not walk. Interview with a MA on 01/13/20 at 10:00am revealed: -She was on her way to Resident #3's room to check on him.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 13 -She did not know Resident #3 had complained of left arm and hand weakness and numbness, and the resident could not walk. Observation of the facility on 01/13/20 at 11:00am revealed: -Emergency Medical Services (EMS) entered the facility with a stretcher and other equipment. -EMS entered Resident #3's room. Observation of Resident #3 on 01/13/20 at 11:05am revealed: -The resident was awake laying on his bed. -The resident was being assessed by EMS staff. -The resident had difficulty moving his left leg with transfer to the EMS stretcher. -The residents' legs were lifted and placed on the stretcher by EMS. Interview with EMS staff on 01/13/20 at 11:07am revealed: -Resident #3's left leg was weak. -They were dispatched to the facility for a "stroke" (A stroke is a medical emergency and occurs when a blood vessel to the brain is either blocked by a clot or bursts preventing the brain from getting oxygen causing brain cells to die. Guidelines suggest treatment with a tissue plasminogen activator (TPA) within three hours of a stroke can dissolve blood clots that prevent the flow of blood to the brain.). Interview with the Health and Wellness Director (HWD) on 01/13/20 at 11:10am revealed: -She received a phone call at 6:00am from staff telling her Resident #3 had fallen. -Resident #3 refused to go to the emergency department after the fall. -She went to Resident #3's room to check on him when she arrived at work at 8:00am today	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 14	D 273		

(01/13/20).
-Resident #3 was at his normal base line when she saw him at 8:00am today (01/13/20).

A second interview with a medication aide (MA) on 01/13/20 at 11:11am revealed:
-She was told in report by night shift staff Resident #3 had vomited, was incontinent of stool and had fallen.
-She was not told what time the fall with vomiting and stool incontinence occurred.
-Resident #3 had not told her he had weakness.

A third interview with the MA on 01/13/20 at 3:05pm revealed:
-She arrived for work at 7:08am today (01/13/20).
-She was told during shift change that Resident #3's fall was unwitnessed.
-She went to check on Resident #3 after she received shift report.
-Resident #3 was sitting in a chair in his room.
-Resident #3 did not act his normal self when she saw him in his room after shift report.
-Resident #3 told her he had gotten dizzy, slipped, and fell.
-Resident #3 did not complain of numbness or weakness in his left arm.
-She did not know Resident #3 had weakness in his left hand until told around 10:00am today.
-She went to check on Resident #3 after she was told the resident had numbness and weakness in his left hand around 10:00am today (01/13/20).
-Resident #3 then told her his left arm and fingers were numb and tingling then his left hand started shaking.
-She told the HWD Resident #3 had numbness and tingling in his left hand with shaking.
-EMS was notified of Resident #3's complaints after she told the HWD Resident #3 complained of numbness and tingling in his left hand with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 15 shaking. Review of Resident #3's electronic medication administration record (eMAR) for January 2020 revealed there was documentation medications were administered by the MA at 8:00am. A fourth interview with the MA on 01/13/20 at 3:15pm revealed: -Around 7:30am today (01/13/20) she went to administer Resident #3 his morning medications -When she went to Resident #3's room the residents left hand was shaking and the resident complained of left-hand numbness. -The resident did not seem his "normal" self. -She asked Resident #3 if he wanted to go to the hospital and the resident refused. -She told the HWD Resident #3's complaint of left-hand numbness with shaking and the resident did not seem his normal self. -The HWD told her to " ...keep an eye ..." on the Resident #3. -She did not return to Resident #3 until around 10:00am today (01/13/20) because she had to assist the other residents to the dining room for breakfast. A second interview with the HWD on 01/13/20 at 3:50om revealed: -She was a Licensed Practical Nurse (LPN). -Residents in Assisted Living (AL) could refuse to be sent to the hospital for evaluation due to unwitnessed falls. -She expected to be notified of unwitnessed falls. -She would provide the falls policy. -She was called and told by the night shift MA Resident #3 had fallen, vomited, and was incontinent of stool, and had refused to go to the hospital. -She told the night shift MA she would follow up	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 16	D 273		

with Resident #3 when she arrived at work today (01/13/20).
-She thought Resident #3 fell while going to the bathroom because he was incontinent of stool and always had an unsteady gait.
-She was not concerned with Resident #3 vomiting because other residents have had colds in the facility.
-She did not think the fall, stool incontinence, and vomiting were related to each other.
-When she saw Resident #3 around 8:00am today (01/13/20) the resident was in his bed and did not seem himself.
-Resident #3 normally ate breakfast in the dining room.
-Resident #3 did not go to the dining room for breakfast today (01/13/20).
-Resident #3 did not tell her he was sick.
-She was going to send Resident #3 to his Primary Care Provider (PCP) today because he had fallen and did not seem himself.
-When the MA went to give Resident #3 his medicines between 9:00am and 10:00am today (01/13/20) the resident told the MA his arm was numb.
-Resident #3 was sent to the hospital instead of his PCP because he developed numbness in his arm.
-The MA did not tell her Resident #3 had arm numbness before 9:00am - 10:00am today (01/13/20).
-She did not tell the MA to monitor Resident #3.

Interview with the Executive Director (ED) on 01/13/20 at 4:15pm revealed:
-He expected residents with unwitnessed falls to be assessed and assisted back to the chair or bed.
-Falls with injuries should be referred to the hospital for evaluation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 17 -Falls should be documented in the 24-hour shift report book. -Falls should be reported to the HWD. -If the HWD was not in the facility, falls should be reported to the PCP. -If residents refused hospital evaluation an appointment should be made with the PCP for evaluation. -The appointment would be made at the discretion of the PCP. -Residents who had fallen, were incontinent, and vomiting should be referred to the hospital for evaluation. -The Power of Attorney would be notified of residents who had fallen, were incontinent, and vomited. -If a resident who had fallen, was incontinent, and vomited refused hospital evaluation, EMS would still be called to evaluate the resident. -EMS would then determine if the resident needed to be sent to the hospital for evaluation. -He did not know Resident #3 had fallen until he asked why EMS was at the facility. -He expected to be notified as soon as EMS was called for a resident. -When Resident #3 reported numbness and tingling in his arm 911 should have immediately called because the facility could not treat the resident. -He expected EMS to have been notified at 6:00am when Resident #3 had fallen, was incontinent, and vomited because no one knew what was wrong with the Resident. -EMS should have been notified when it was noticed Resident #3 was not acting his normal self at 8:00am today (01/13/20). -When Resident #3 first reported numbness and tingling down his arm EMS should have been called before reporting to the HWD.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 18	D 273		

Telephone interview with a nurse at a local hospital on 01/13/20 at 5:25pm revealed:
-Resident #3 had been admitted to the hospital.
-Resident #3 was being evaluated for a "stroke".

Telephone interview with a second MA on 01/13/20 at 5:35pm revealed:
-She found Resident #3 on his bathroom floor around 6:00am today (01/13/20).
-Resident #3 was last seen by the personal care aide (PCA) at 4:00am today (01/13/20) during every 2-hour rounds.
-Every 2-hour rounds were not documented.
-Resident #3 was incontinent of stool.
-There was stool from Resident #3's bedroom floor to the bathroom floor.
-There was stool on Resident #3's hands and feet.
-There was vomit on Resident #3's bedroom floor right in front of the bathroom.
-Resident #3 told her had gotten dizzy and fell.
-Resident #3 told her he had been on the floor for " ...a few hours".
-She helped Resident #3 to a chair in his room.
-Resident #3 did not complain of numbness or tingling or leg weakness.
-Resident #3 refused to go to the hospital for evaluation.
-She called the HWD and told her Resident #3 was found on the bathroom floor, had vomited, was incontinent of stool, and refused to go to the hospital.
-She told the HWD Resident #3 needed to be sent to the hospital because the resident was incontinent of a lot of stool, had vomited, and was uncertain how long the resident had been on the floor.
-The HWD told her she would send Resident #3 to the PCP today (01/13/20).
-Residents with unwitnessed falls were to have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 19	D 273		

vital signs taken and document.
-She had never had training at the facility on residents with changes in condition.

Telephone interview with a PCA on 01/16/20 at 7:45am revealed:
-She worked third shift on 01/12/20.
-She made rounds on Resident #3 between 5:00am - 5:15am on 01/13/20.
-Resident #3 was laying in bed awake.
-She spoke to Resident #3 and the resident did not have complaints.
-Around 6:00am on 01/13/20 the MA asked her to help clean Resident #3.
-When she went with the MA to Resident #3's room she saw the resident on the bathroom floor.
-The resident was incontinent of stool and there was vomit on the floor by Resident #3's bed.
-It was not normal for Resident #3 to be incontinent of stool.
-Resident #3's blood pressure was 160/65.
-Resident #3 denied complaints.
-Resident #3 refused transport to the emergency department.
-She did not know if Resident #3's PCP was called.

Telephone interview with Resident #3's Power of Attorney (POA) on 01/14/20 at 8:40am revealed:
-She was called by the MA on 01/13/20 at 10:59am and told the resident was found on the floor, later complained of tingling in his arm, and EMS was called.
-She was not told when the fall occurred.
-She saw the resident on 01/11/20 and the resident did not have any problems.
-The resident had never had a stroke.
-The resident had never had left arm weakness.
-She saw the resident in the hospital 01/13/20 and he told her he "felt weird" on the night of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 20	D 273		

01/12/20, could not grab things, slipped off his bed, and vomited.
-The resident was confused with slurred speech in the hospital on 01/13/20.
-She expected the facility to have called her when the resident was found on the floor at 6:00am.
-She would have made the decision to send the resident to the hospital because it was unknown how the resident fell or how long the resident had been on the floor.
-If the resident was having a stroke at that time, the hospital could may have administered " ...TPA ..." (Tissue plasminogen activator (TPA) is a medication administered to stroke victims to dissolve blood clots).
-Resident #3's hospital provider thought he had a stroke.
-The residents hospital provider told her TPA could not be administered because they were unsure when the stroke began.

Telephone interview with second nurse at a local hospital for Resident #3 on 01/14/20 at 9:10am revealed:
-Resident #3 had left facial droop and left side weakness.
-Resident #3 was being evaluated for a stroke.
-Additional information could not be disclosed.

A second interview with Resident #3's POA on 01/14/20 at 10:45am revealed:
-She had come to the facility to pick up some of Resident #3's belongings.
-She was not told Resident #3 had fallen in the bathroom until now.
-Resident #3 had a significant change in memory since she saw the resident on 01/11/20.
-Resident #3 now could not sit upright without leaning to the left.
-Resident #3 now could not raise his left arm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 21	D 273		

above his chest.
-Resident #3's left leg was now slower in movement than the right.
-Resident #3 now had slurred speech.
-Resident #3 did not have leaning to the left, limited lifting of the left arm, left leg weaker than right, or slurred speech when she saw the resident on 01/11/20.

Telephone interview with Resident #3's PCP on 01/16/20 at 1:26pm revealed:
-He last evaluated the resident at the facility on 12/20/19.
-The resident had hypertension and mild cognitive impairment on 12/20/19.
-He expected to be notified of any falls.
-He had not been notified Resident #3 had fallen on 01/13/20.
-He did receive a fax from the facility on 01/13/20 that the resident was sent to the emergency department because of a fall.
-He expected staff to have called him when the resident was found on the bathroom floor with stool incontinence and vomit by the bed.
-He would have made the determination to send the resident to the hospital based on the resident's level of consciousness and behavior.
-The resident had memory problems and could not safely refuse transport to the hospital.

Review of a local hospital emergency department note for Resident #3 dated 01/13/20 revealed:
-The resident fell from bed around 6:00am today (01/13/20)
-The resident arrived at the emergency department as a code stroke/trauma alert with left arm weakness, left facial droop, slurred speech, and was leaning to the left side.
-The resident had a soft tissue contusion to the back of the head. (A contusion is a bruise often

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 22	D 273		

sustained from a blunt force such as a fall, or blow. The result is pain, swelling, and discoloration because of bleeding into the tissue.).

Review of a local hospital history and physical provider note for Resident #3 dated 01/13/20 revealed:
-The resident was transported to the emergency department as a "Code Stroke".
-The resident was outside the window to receive TPA.
-The resident's blood pressure was 192/93 (Normal blood pressure is less than 120/80).
-The resident had hypertension in the setting of probable new stroke.
-The resident had left sided facial droop and left-hand grip weakness with decreased coordination.
-The resident was admitted for acute left sided weakness and slurred speech.

Review of a Computed Tomography Angiography (CTA) for Resident #3 dated 01/13/20 revealed (A CTA is an imaging test that looks at vessels in the brain to help diagnose a stroke):
-The left posterior cranial artery was abnormal with intermittent visualization of the vessel which may have been related to narrowing or partial occlusion.
-A brain Magnetic Resonance Imagery (MRI) was recommended (An MRI is an imagery test that can be used to diagnose strokes).

b. Review of a physician's order sheet for Resident #3 dated 11/21/19 revealed there was an order for Physical Therapy (PT) to evaluate and treat for gait instability and falling.

Review of Resident #3's progress notes from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 23 08/30/19 - 01/07/20 revealed there was no documentation the resident had been evaluated by PT per the 11/21/19 physicians order. Review of the home health (HH)/agency documentation flow sheet revealed there was no documentation the resident had been evaluated by PT per the 11/21/19 physicians order. Interview with a MA on 01/13/20 at 3:05pm revealed: -Resident #3 had an unwitnessed fall around 6:00am today (01/13/20). -Resident #3 was sent to the emergency department today (01/13/20). -Resident #3 had fallen a lot. -She could not remember when Resident #3 had fallen. Telephone interview with Resident #3's Power of Attorney (POA) on 01/15/20 at 4:00pm revealed: -The resident had fallen since being at the facility. -She did not know the resident was referred for PT on 11/21/19. -She thought the resident told her he was receiving PT in December 2019. -She expected the resident to have PT if it was ordered. -If the resident had refused PT, she could have encouraged him to have the therapy because the resident knew she had his best interest at heart and would have listened to her. -She wanted the resident to have a good quality of life. Telephone interview with a representative from Resident #3's Primary Care Provider (PCP) office on 01/14/20 at 11:30am revealed: -There was no documentation Resident #3 had received PT.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 24 -There was no documentation Resident #3 had refused PT. Interview with the Health and Wellness Director (HWD) on 01/15/20 at 10:30am revealed: -She did not remember the 11/21/19 PT order for Resident #3. -She would attempt to locate a PT evaluation per the 11/21/19 PT order. Interview with the Executive Director (ED) on 01/15/20 at 5:30pm revealed: -PT would document in a HH log book when residents were seen. -The documentation would include when, why, and by whom the resident was seen. -The HH log book was reviewed by the HWD. -The HWD would call the family and PCP if the resident was not documented as seen by PT because the referral would still need to take place. A second interview with the ED on 01/16/20 at 3:30pm revealed: -The HWD was responsible for making PT referrals. -The HWD would either fax or call PT orders to the home health agency. -He expected the orders to be sent by the next business day after the order was received from the PCP. -If the HWD director was not available to send the order, the Regional Nurse would make the referral. Interview with the HWD on 01/16/20 at 4:50pm revealed: -She and the Resident Care Coordinator (RCC) were responsible for reviewing orders. -She and the RCC were responsible for sending	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 25	D 273		

therapy orders to the HH agencies.
-Normally therapy would report to her the resident's evaluation results.
-There was no system in place to ensure therapy referrals were completed.

Requests to the HWD for Resident #3's PT notes for the 11/21/19 PT order were not provided by survey exit on 01/16/20.

Attempted telephone interview with Resident #3's PCP on 01/14/20 at 11:30am was unsuccessful.

Resident #3 was not available for interview from 01/14/20 - 01/16/20.

2. Review of Resident #1's current FL-2 dated 12/19/19 revealed:
-Diagnoses to include syncope, orthostasis, acute cystitis without hematuria, dementia, diabetes mellitus type II, chronic diastolic congestive heart failure, chronic kidney disease stage III, blindness of the right eye with category 3 blindness of the left eye, essential hypertension, old cerebral vascular accident with cognitive deficits.
-An order for physical therapy (PT) and occupational therapy (OT) to evaluate and treat, maximum effect.

Review of Resident #1's records revealed:
-Resident #1 had been hospitalized from 12/17/19 and discharged on 12/19/19.
-Resident #1 discharge diagnoses included syncope, orthostasis, acute cystitis without hematuria.
-The order for PT and OT to evaluate and treat Resident #1 were documented on the FL-2 dated 12/19/19.
-No documentation that Resident #1 had been evaluated by PT and OT.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 26 -No documentation of a treatment plan for Resident #1 from PT and OT. -No documentation by facility staff or PT and OT that Resident #1 had received any PT or OT since the order was written 12/19/19. Review of Resident #1's ER discharge dated 01/09/20 revealed: -Resident #1 was sent out to the ER via EMS after an unwitnessed fall out of her wheelchair. -Resident #1's chief complaint was trauma alert, fall when she presented to the ER. -Her discharged diagnoses included closed head injury, initial encounter and traumatic hematoma of forehead, initial encounter. Interview with a medication aide (MA) on 01/15/20 at 4:00 p.m. revealed: -Resident #1 did not receive PT or OT. -The Health and Wellness Director reviewed all FL-2s, discharge summaries and processed the orders off. Interview with Resident #1's Power of Attorney (POA) on 01/16/20 at 1:30 p.m. revealed: -He was not aware there was an order for Resident #1 to receive PT and OT. -He gave the discharge paperwork from Resident#1's 12/19/19 hospital visit to a staff at the facility. -He could not recall which facility staff he gave the 12/19/19 discharge paperwork. -He did not know why PT or OT would be ordered for Resident #1 except that she had complained of right shoulder pain from "rotator cuff issues". -If there was an order for Resident #1 to have PT and OT, he would expect the facility to carry out the order. -He did not know why the facility did not make the referral for the PT and OT ordered 12/19/19.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 27 -They were usually very good at making sure that orders for Resident #1 were done. Interview with the Health and Wellness Director (HWD) on 1/16/20 at 4:48 p.m. revealed: -When a referral was ordered for PT and OT, she would fax the order to home health agency. -The home health agency usually comes out to see the resident within 24 hours. -After she faxed the order, she stapled the fax confirmation to the order form and placed it in the resident's records. -She did not know if the referral order for PT and OT to evaluate and treat Resident #1 were completed. -Normally PT or OT would update her on the evaluation results for the resident. -She did not recall having had a conversation with PT or OT about evaluation results for Resident #1. -The facility did not have a system in place to follow-up on referral orders to make they were done. Interview with the Executive Director (ED) on 1/16/20 at 3:58 p.m. revealed: -The HWD was responsible for making sure the referral orders were done. -The facility usually made the request for the referral order for PT or OT the next business day after receiving the order. -He did not know if the referral order from 12/19/19 for Resident #1 to be evaluated and treated by PT and OT was done. -Usually there would be documentation by PT and OT in the home health care binder when they had visited the resident. -When the documentation by PT and OT were full, they were placed in the resident's records. -Part of the facility's procedure was to follow-up	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 273	Continued From page 28 by checking to make sure the referral order had been done. -If the referral order was not done then the HWD needed to call and follow-up to make sure the order is done. _____ The facility failed to assure the referral of two residents (#3, #1), Resdent #3 who had cognitive impariment sustained an unwitnessed fall with nausea and vomiting, incontinenence of stool and later developed left arm weakness with inability to ambulate was referred to the emergency room for evaluation approximately 5 hours after the unwitnessed fall, where he progressed to slurred speech, left facial droop, and left side weakness and was admitted for stroke testing; another Resident #1 who was ordered a referral for physical therapy and occupational therapy were not done. The facility's failure to perform these referrals resulted in Resident #3's admission for stroke testing after he progressed to having slurred speech, left facial droop, and left sided weakness; and Resident #1 having a fall resulting in head trauma and hematoma to her forehead. The facility's failure resulted in serious injury and neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/13/20 for this violation. THE CORRECTION DATE FOR THE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 15, 2020.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 276	Continued From page 29 (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 2 of 5 sampled residents (#2 and #3). Resident #2 had a laboratory test ordered for July and October 2019 which was not completed and Resident #3's blood pressure was not re-assessed in a resident diagnosed with hypertension who was on three blood pressure medications and 13 days later was arrived at the emergency department with left facial droop, slurred speech, and left sided weakness where he was admitted with a blood pressure of 130/103 and a possible stroke. The findings are: 1. Review of Resident #2's current FL-2 dated 04/23/19 revealed: -Diagnoses included atrial fibrillation (A-fib), dementia, gastroesophageal reflux disease (GERD), hypothyroidism, mood disorder, rheumatoid arthritis, and Type 2 Diabetes	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 276	Continued From page 30 Mellitus. Review of the January 2020 medication administration record (MAR) revealed the diagnoses of rheumatoid arthritis, abnormal gait, depression, essential (primary) hypertension, congestive heart failure (CHF), and heart failure unspecified. Review of a physician order dated 04/02/19 for Resident #2 revealed an order to repeat comprehensive metabolic panel (CMP) (a blood test that measured glucose level, electrolyte and fluid balance, kidney function, and liver function) every 3 months. Review of Resident 2#'s record revealed there was no documentation of the CMP laboratory results for July and October 2019. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Interview with the Health and Wellness Director (HWD) on 01/16/20 at 8:25am: -The primary care physician (PCP) always sent the laboratory orders to a laboratory services company. -She had never heard of any missed laboratory orders for the PCP. -She assumed the laboratory order dated 04/02/19 to obtain a CMP every 3 months was being followed through by the PCP and did not discover the missing laboratory results until 01/16/20. Telephone interview with the PCP on 01/15/20 at 3:52pm revealed: -The order dated 04/02/19 to obtain a	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 276	Continued From page 31	D 276		

comprehensive metabolic panel (CMP) every 3 months was written due to Resident #2 having a slightly low glomerular filtration rate (GFR) (a test used to check how well the kidneys are working).
-The PCP would send the laboratory requisition to her office team and the laboratory requisition would be entered into their ordering system.
-In June 2019, a new computer system was implemented within her office and the laboratory order dated 04/02/2019 was not transferred from the previous computer system.

Interview with the Executive Director (ED) on 01/16/20 at 10:45am revealed:
-For resident's laboratory orders, the PCP would notify the medical laboratory company with applicable orders and the facility was given the PCP's written order to maintain in the resident's medical record.
-It was the responsibility of the HWD to process any orders.
-If the order was the facility's responsibility, staff should use outlook or the medication administration record (MAR) for reminders to ensure the completion of the PCP's orders.
-The facility was responsible for all orders.

A second telephone interview with the PCP on 01/16/20 at 12:10pm revealed:
-Resident #2's GFR was 38 (reference range 90-120) on 08/08/18.
-Resident #2's GFR was 31 on 02/11/19.
-She discovered on 01/16/20 the laboratory order dated 04/02/19 to obtain a CMP every three months was not completed in July and October 2019.
-She re-ordered the CMP for Resident #2 today, 01/16/20.
-The outcome to Resident #2 not having the CMP drawn in July and October 2019 was chronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 276	Continued From page 32 kidney disease (CKD) however CKD was "untreatable." -Her expectation for the facility would be to follow up to ensure completion of any PCP orders. 2. Review of Resident #3's current FL-2 dated 09/17/19 revealed: -Diagnoses included hypertension and diabetes. -There was an order for Amlodipine 5mg daily (Amlodipine is a medication used to treat high blood pressure). -There was an order for Losartan/Hydrochlorothiazide (HCTZ) 100/25mg daily (Losartan/HCTZ is a medication used to treat high blood pressure). -There was an order for Metoprolol 50mg twice daily (Metoprolol is a medication used to treat high blood pressure). Review of a Resident #3's physician's order dated 09/18/19 revealed an order to assess blood pressure (BP) every week. Notify physician for systolic BP greater than 160 and diastolic BP greater than 90. Review of Resident #3's fax cover sheet dated 01/01/20 revealed: -There was documentation the resident's BP was 170/76 "please advise". -There was an order dated 01/02/20 to repeat BP "today" and contact the Primary Care Provider (PCP) for systolic over 160 and diastolic over 90. Review of Resident #3's electronic medication record (eMAR) for January 2020 revealed: -There was an entry to check and record BP weekly. Notify PCP if systolic is greater than 160 or diastolic is greater than 90. -There was documentation the residents BP was 170/76 on 01/01/20.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 276	Continued From page 33 -There was documentation the residents BP was not due on 01/02/20. -There was no documentation the residents BP was assessed on 01/02/20. Review of Resident #3's progress notes from 08/30/19 - 01/07/20 revealed: -There was no documentation the residents BP was assessed on 01/02/20. -There was no documentation the resident's PCP was contacted regarding a BP on 01/02/20. Interview with a medication aide (MA) on 01/16/20 at 8:06am revealed: -She believed the Health and Wellness Director (HWD) and Resident Care Director (RCD) received faxed physician orders. -Once the orders were received the HWD or RCD would enter the orders on the eMAR. -Once the orders were entered in the resident's eMAR they would let the MA know the resident had orders. -She was not working when the 01/02/20 order to reassess Resident #3's BP was received. Telephone interview with Resident #3's PCP on 01/16/20 at 1:26pm revealed: -He saw the resident at the facility on 12/20/19. -On 12/20/19 the resident's BP was 192/105. -The resident's BP was reassessed on 12/20/19 and was 150/80. -On 12/03/19 the resident's BP was 160/86. -On 11/22/19 the resident's BP was 173/90. -On 10/18/19 the resident's BP was 172/95. -He wanted weekly BP checks on the resident because the resident's BP was too high on 12/20/19. -The reason he wanted the resident's BP rechecked on 01/02/20 was because of the resident's history of elevated BP's.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 276	Continued From page 34 -He expected the residents BP to be reassessed on 01/02/20 per orders because the residents systolic BP was above 160. -He would have adjusted the resident's BP medications if the BP was greater than 160/90 on 01/02/20. Interview with the HWD on 01/16/20 at 4:50pm revealed: -She and the RCD were responsible for reviewing orders. -She did not remember seeing the order to reassess Resident #3's BP on 01/02/20. Interview with the Executive Director (ED) on 01/16/20 at 11:00am revealed: -The HWD was responsible for processing orders. -It was the facility's responsibility to ensure orders were followed.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 358	Continued From page 35 Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's medication policies for 1 of 6 residents (#8) observed during the medication passes including errors with a cardiac medication and a vitamin supplement. The findings are: The medication error rate was 7% as evidenced by the observation of 2 errors out of 26 opportunities during the 12:00pm medication passes on 01/13/20 and the 8:00am medication pass on 01/15/20. a. Review of Resident #8's current FL-2 dated 12/16/19 revealed: -Diagnoses included chronic atrial fibrillation (a-fib), hypertension, cardiomyopathy, mitral regurgitation, and right above the knee amputation. -There was an order for Digoxin 0.0625 milligrams (mg) daily. Hold for pulse less than (<) 60. (Digoxin is a medication used to treat heart failure by strengthening the heart's contractions and slowing the heart rate in patients with a-fib). Observation of the 8:00am medication pass on 01/15/20 revealed: -Resident #8 was in a wheelchair on hall A by the medication cart. -The medication aide (MA) prepared and administered Resident #8's morning medicines including Digoxin at 7:41am. -The MA did not assess Resident #8's pulse. Interview with the medication aide (MA) on 01/15/20 at 3:06pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 358	Continued From page 36 -She would compare the order on the eMAR with the medication packet prior to popping the medicine in the medication cup for residents. -She had never noticed the documentation on Resident #8's eMAR "hold for pulse < 60". -The eMAR did not alert to hold for pulse <60 prior to administering Resident #8's Digoxin. -Resident #8's eMAR did not contain a place to document the resident's pulse prior to administering Digoxin. -She had never assessed Resident #8's pulse prior to administering Digoxin to the resident because she never noticed that part of the order. Review of Resident #8's eMAR for January 2020 revealed: -There was an entry for Digoxin 0.0625 mg daily, hold if pulse < 60 to be administered at 8:00am. -There was documentation Digoxin was administered on 01/15/20 at 8:00am. -There was no documentation the resident's pulse was assessed prior to administration of the Digoxin. Interview with the Health and Wellness Director (HWD) on 01/15/20 at 3:15pm revealed: -The MA's were expected to follow the orders in the resident's eMAR prior to administration of medications. -She expected the MA to have assessed Resident #8's pulse prior to administration of Digoxin because the Digoxin could lower the resident's pulse. -If Resident #8's pulse was < 60 she expected the MA to have held the Digoxin and call the resident's Primary Care Provider (PCP). -The Licensed Health Professional Support (LHPS) nurse would teach the MA's how to read the eMARs prior to being released to work on the medication cart.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 358	Continued From page 37 Interview with Resident #8 on 01/15/20 at 3:20pm revealed the MA's had never assessed her pulse before administering medications. Interview with the Resident Care Director (RCD) on 01/15/20 at 3:40pm revealed: -She and the Memory Care Director (MCD) trained the MA's how to read the orders in the eMAR prior to being released on the medication cart to administer resident medications. -She expected the MA to have assessed Resident #8's pulse prior to administration of Digoxin because the Digoxin could cause lower the resident's pulse. -The MA was expected to hold the Digoxin if Resident #8's pulse was < 60. Telephone interview with a representative from the facility's pharmacy on 01/15/20 at 4:18pm revealed: -The facility was supposed to verify orders with the eMAR to ensure orders were entered correctly. -The eMAR should prompt for a pulse to be entered when there was an order to hold for pulse < 60. -Resident #8's eMAR did not prompt for a pulse to be entered with the Digoxin because the facility did not verify orders with the eMAR to ensure there was a prompt to enter the resident's pulse. Telephone interview with a pharmacist for the facility's pharmacy on 01/15/20 at 4:25pm revealed: -It was expected to assess Resident #8's pulse prior to administration of Digoxin because the Digoxin could lower the resident's pulse. -The outcome of a low pulse would be resident specific depending on what the resident could tolerate.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 358	Continued From page 38 -A pulse < 60 was low for most people. Telephone interview with Resident #8's PCP on 01/16/20 at 11:45am revealed: -The resident was prescribed Digoxin to treat cardiomyopathy. -The resident had a weak heart. -The Digoxin controlled the resident's heart rate by keeping a high pulse within normal range. -The Digoxin stimulated the resident's weak heart to contract. -If Digoxin was administered with the resident's pulse < 60 the resident could experience shortness of breath and chest discomfort. -She expected the facility to follow physician orders for the resident. -She expected the resident's pulse to be assessed prior to administration of Digoxin because Digoxin could lower the resident's pulse. b. Review of Resident #8's current FL-2 dated 12/16/19 revealed: -Diagnoses included chronic atrial fibrillation (a-fib), hypertension, cardiomyopathy, mitral regurgitation, and right above the knee amputation. -There was an order for multivitamin take one tablet daily. Observation of the 8:00am medication pass on 01/15/20 revealed: -Resident #8 was in a wheelchair on hall A by the medication cart. -The MA searched through the medication cart drawers. -The MA prepared and administered Resident #8's morning medications at 7:41am. -The multivitamin was not administered. Interview with the medication aide (MA) on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 358	Continued From page 39 01/15/20 at 7:36am revealed: -Resident #8's family provided the residents medications. -Resident #8 did not have a multivitamin for administration on the medication cart. -She would ask the Resident Care Director (RCD) about Resident #8's multivitamin. A second interview with the MA on 01/15/20 at 7:45am revealed: -The Resident Care Director (RCD) called Resident #8's family 01/14/20 and told them the resident needed a refill on the multivitamin. -Resident #8's multivitamin would be brought today (01/15/20). Review of Resident #8's electronic medication administration record for January 2020 revealed: -There was an entry for a multivitamin daily to be administered at 8:00am. -There was documentation the multivitamin was a missed dose on 01/25/20 at 8:00am. -There was no documentation why the multivitamin was a missed dose. Interview with the Executive Director (ED) on 01/15/20 at 2:50pm revealed: -The Health and Wellness Director (HWD), Memory Care Director (MCD), and Medication Aide/Supervisor (MA/S) performed weekly medication cart audits. -Sometimes the cart audits were performed twice weekly on carts that were high use carts. -The eMAR would be compared to the medications in the cart to ensure all medications were available for administration. -Medications would be reordered during cart audits to ensure resident medications were always available for administration. -The HWD or MCD would fax the medication	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 358	Continued From page 40	D 358		

reorder sheet to the pharmacy.
-The medications would be delivered to the facility that evening or the next day.
-He expected resident medications to always be available for administration.

Interview with Resident #8 on 01/15/20 at 3:20pm revealed she had not been administered a multivitamin after the 8:00am medication pass today (01/13/20).

Interview with the HWD on 01/15/20 at 3:30pm revealed:
-Medication cart audits were performed weekly.
-Medications were reordered when there was a seven-day supply left.
-If family provided resident medications, the family would be told the medication was needed.
-If the family did not provide the needed medications within 1 day the facility would obtain the medications.
-If the resident's family was unavailable to provide the medications the facility had to order the medications from the pharmacy because the facility had to follow physician orders.

Telephone interview with a representative from the facility's pharmacy on 01/15/20 at 4:18pm revealed:
-Resident #8's family provided the multivitamin for Resident #8.
-The facility would normally send Resident #8's medications provided by the family to the pharmacy for repackaging.
-They were repackaging some medications for Resident #8 today (01/15/20).
-They were not repackaging Resident #8's multivitamin today (01/15/20).
-No one had contacted them for a refill on Resident #8's multivitamin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 358	Continued From page 41 Interview with the RCD on 01/15/20 at 4:30pm revealed: -She had told Resident #8's family on 01/14/20 the resident needed a refill on the multivitamin. -Resident #8's family was out of town and would provide the multivitamin when they returned. Interview with a second MA on 01/16/20 at 8:06am revealed: -She performed a cart audit about one month ago. -When she performed a cart audit, she would reorder medications when there were seven days of medication left in the pack. -She would call family to refill an over the counter (OTC) medication when there were five to seven pills left in the bottle. -She would order the medication from the pharmacy if the OTC medication was not provided by the family before the medication ran out. Telephone interview with Resident #8's Primary Care Provider (PCP) on 01/16/20 at 11:45am revealed: -She did not know why she ordered the resident a multivitamin. -It may have been because she wanted to be certain the resident received the needed vitamins because the resident may not have eaten well. -She expected the facility to follow physician orders. -She expected the multivitamin to have been administered to the resident. -She expected the facility to ensure the resident's medications were always available for administration. _____ The facility failed to assure a Resident #8, who	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 358	Continued From page 42 had a diagnosis of atrial fibrillation and cardiomyopathy, had a pulse checked prior to administering a heart medication that decreases the pulse rate which placed the resident at risk for a low pulse. The facility's failure was detrimental to the health, safety, and welfare of the resident which constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/13/20 for this violation.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to complete observations for 1 of 5 residents sampled (#2) taking ordered medications (an antihypertensive, blood thinner, antiarrhythmic, diuretic, and a vitamin) in accordance with the facility's medication policies.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 43 The findings are: Review of Resident #2's current FL-2 dated 04/23/19 revealed diagnoses included atrial fibrillation (A-fib), dementia, gastroesophageal reflux disease (GERD), hypothyroidism, mood disorder, rheumatoid arthritis, and type two diabetes. Review of the January 2020 medication administration record (MAR) revealed the diagnoses of rheumatoid arthritis, abnormal gait, depression, essential (primary) hypertension, congestive heart failure (CHF), and heart failure unspecified. a. Review of a physician order for Resident #2 dated 04/23/19 revealed Cozaar (used in treatment for high blood pressure) 50mg tablet daily. Review of the January 2020 electronic medication administration records (eMARs) for Resident #2 revealed: -There was an entry for Cozaar (Losartan) tab 50mg take 1 tablet by mouth once daily to be administered at 9:00am. -There was documentation on 01/12/20 and 01/13/20 that Resident #2 was administered Cozaar 50 mg. Observation of Resident #2's room on 01/13/20 at 9:48am revealed: -Resident #2 was sitting in a chair. -Beside the chair was a small table. -On the table was a white, paper medicine cup. -In the medicine cup were four pills and 1 capsule. -One pill was round and white. -One pill was round and yellow.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 44 -One pill was oblong and white. -One pill was triangle shaped and brownish red color. -The capsule was oblong, white on one end and blue on the other end. Based on observations, record reviews and interviews, Resident #2 resident was not interviewable. Interview with Medication Aide (MA) on 01/13/20 at 3:15pm revealed: -When administering medications to residents, she followed the physician orders on the electronic medication administration record (eMAR). -She would clean her hands and apply gloves. -She would make sure the resident was in the facility and awake. -If the resident was not available at the time of administration, she would dispose of the medications. -For Resident #2, she left her medications in her room on 01/12/20 and 01/13/20. -Resident #2's husband (Resident #4) made sure that Resident #2 took her medications. -Yesterday (01/12/20) Resident #4 told her to leave Resident #2's medications with him because Resident #2 was in the restroom or either asleep. -Today (01/13/20) she left Resident #2's medications with Resident #4 because Resident #2 was in the bathroom. -She was "comfortable" with leaving Resident #2's medications with Resident #4 because she knew that he would make sure that Resident #2 took her medications. Telephone interview with the Primary Care Provider (PCP) on 01/15/20 at 3:30pm revealed:	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 45 -She was not aware Resident #2's medication cup containing Cozaar 50 mg, Folic Acid 1 mg, HCTZ 12.5 mg, Xarelto 20mg, and Amiodarone 200mg daily was left by the MA in Resident #2's room on 01/12/20 and 01/13/20. -Her expectation would be for the MA to administer the medications as ordered for Resident #2 and to be notified the same day of any missed medication doses. -Her concerns were related to the missed doses of Xarelto and Cozaar due to Resident #2's medical history of A-Fib (an irregular, often rapid heart rate that can increase the risk of strokes, heart failure, and other heart-related complications). -A major concern with Resident #2's was the potential to develop blood clots. -The outcomes to Resident #2 due to missed medication doses were an elevated heart rate and the possibility of blood clots. -The resident was on Xarelto as a preventive measure for blood clots. Interview with the Pharmacy Consultant on 01/16/20 at 11:09am revealed: -She was not aware Resident #2's medication cup containing Cozaar 50 mg, Folic Acid 1 mg, HCTZ 12.5 mg, Xarelto 20mg, and Amiodarone 200mg daily was left by the medication aide (MA) in Resident #2's room on 01/12/20 and 01/13/20. -Medications should be administered to the residents as ordered. -The MAs should witness the resident take the medications brought into the room. -The PCP should be notified of any missed medication doses. -Residents should not self-medicate without a physician's order. -Due to the missed medication doses of Cozaar and Xarelto, she agreed with the Resident #2's	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 46	D 366		

PCP the outcomes to Resident #2 were an elevated heart rate and the possibility of blood clots.

Refer to interview with a family member for Resident #2 on 01/13/20 at 9:45am.

Refer to the interview with the Health and Wellness Director (HWD) on 01/13/20 at 3:52pm.

Refer to the interview with the Executive Director (ED) on 01/13/20 at 4:38pm.

Refer to the interview with a family member for Resident #2 on 01/14/2020 at 8:35am.

b. Review of a physician order for Resident #2 dated 04/23/19 revealed Folic Acid (used in treatment of anemia) 1 mg daily.

Review of the January 2020 electronic medication administration records (eMARs) for Resident #2 revealed:
-There was an entry for Folic Acid 1mg tab take 1 tablet by mouth once daily to be administered at 9:00am.
-There was documentation on 01/12/20 and 01/13/20 that Resident#2 was administered Folic Acid 1 mg tablet.

Interview with Medication Aide (MA) on 01/13/20 at 3:15pm revealed:
-When administering medications to residents, she followed the physician orders on the electronic medication administration record (eMAR).
-She would clean her hands and apply gloves.
-She would make sure the resident was in the facility and awake.
-If the resident was not available at the time of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 47	D 366		

administration, she would dispose of the medications.
-For Resident #2, she left her medications in her room on 01/12/20 and 01/13/20.
-Resident #2's husband (Resident #4) made sure that Resident #2 took her medications.
-Yesterday (01/12/20) Resident #4 told her to leave Resident #2's medications with him because Resident #2 was in the restroom or either asleep.
-Today (01/13/20) she left Resident #2's medications with Resident #4 because Resident #2 was in the bathroom.
-She was "comfortable" with leaving Resident #2's medications with Resident #4 because she knew that he would make sure that Resident #2 took her medications.

Telephone interview with the Primary Care Provider (PCP) on 01/15/20 at 3:30pm revealed:
-She was not aware Resident #2's medication cup containing Cozaar 50 mg, Folic Acid 1 mg, HCTZ 12.5 mg, Xarelto 20mg, and Amiodarone 200mg daily was left by the MA in Resident #2's room on 01/12/20 and 01/13/20.
-Her expectation would be for the MA to administer the medications as ordered for Resident #2 and to be notified the same day of any missed medication doses.

Refer to interview with a family member for Resident #2 on 01/13/20 at 9:45am.

Refer to the interview with the Health and Wellness Director (HWD) on 01/13/20 at 3:52pm revealed.

Refer to the interview with the Executive Director (ED) on 01/13/20 at 4:38pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 48 Refer to the interview with a family member for Resident #2 on 01/14/2020 at 8:35am. Refer to the telephone interview with the PCP on 11/15/20 at 3:30pm. Refer to the interview with the Pharmacy Consultant on 01/16/20 at 11:09am. c. Review of a physician order for Resident #2 dated 04/23/19 revealed Hydrochlorothiazide (HCTZ, a diuretic used in treatment of high pressure and fluid retention) 12.5 mg daily. Review of the January 2020 electronic medication administration records (eMARs) for Resident #2 revealed: -There was an entry for Hydrochlorothiazide (HCTZ) cap 12.5 mg take one capsule by mouth to be administered every morning. -There was documentation on 01/12/20 and 01/13/20 that Resident #2 was administered HCTZ 12.5 mg. Interview with Medication Aide (MA) on 01/13/20 at 3:15pm revealed: -When administering medications to residents, she followed the physician orders on the electronic medication administration record (eMAR). -She would clean her hands and apply gloves. -She would make sure the resident was in the facility and awake. -If the resident was not available at the time of administration, she would dispose of the medications. -For Resident #2, she left her medications in her room on 01/12/20 and 01/13/20. -Resident #2's husband (Resident #4) made sure that Resident #2 took her medications.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 49 -Yesterday (01/12/20) Resident #4 told her to leave Resident #2's medications with him because Resident #2 was in the restroom or either asleep. -Today (01/13/20) she left Resident #2's medications with Resident #4 because Resident #2 was in the bathroom. -She was "comfortable" with leaving Resident #2's medications with Resident #4 because she knew that he would make sure that Resident #2 took her medications. Telephone interview with the Primary Care Provider (PCP) on 01/15/20 at 3:30pm revealed: -She was not aware Resident #2's medication cup containing Cozaar 50 mg, Folic Acid 1 mg, HCTZ 12.5 mg, Xarelto 20mg, and Amiodarone 200mg daily was left by the MA in Resident #2's room on 01/12/20 and 01/13/20. -Her expectation would be for the MA to administer the medications as ordered for Resident #2 and to be notified the same day of any missed medication doses. Refer to interview with a family member for Resident #2 on 01/13/20 at 9:45am. Refer to the interview with the Health and Wellness Director (HWD) on 01/13/20 at 3:52pm revealed. Refer to the interview with the Executive Director (ED) on 01/13/20 at 4:38pm. Refer to the interview with a family member for Resident #2 on 01/14/2020 at 8:35am. Refer to the telephone interview with the PCP on 11/15/20 at 3:30pm.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 50 Refer to the interview with the Pharmacy Consultant on 01/16/20 at 11:09am. d. Review of a physician order for Resident #2 dated 04/23/19 revealed Xarelto (used in treatment for prevention of blood clot formation) 20mg daily. Review of the January 2020 electronic medication administration records (eMARs) for Resident #2 revealed: -There was an entry for Xarelto tab 20mg take 1 tablet by mouth once daily to be administered at 9:00am. -There was documentation on 01/12/20 and 01/13/20 that Resident#2 was administered Xarelto 20mg tablet. Interview with Medication Aide (MA) on 01/13/20 at 3:15pm revealed: -When administering medications to residents, she followed the physician orders on the electronic medication administration record (eMAR). -She would clean her hands and apply gloves. -She would make sure the resident was in the facility and awake. -If the resident was not available at the time of administration, she would dispose of the medications. -For Resident #2, she left her medications in her room on 01/12/20 and 01/13/20. -Resident #2's husband (Resident #4) made sure that Resident #2 took her medications. -Yesterday (01/12/20) Resident #4 told her to leave Resident #2's medications with him because Resident #2 was in the restroom or either asleep. -Today (01/13/20) she left Resident #2's medications with Resident #4 because Resident	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 51	D 366		

#2 was in the bathroom.
-She was "comfortable" with leaving Resident #2's medications with Resident #4 because she knew that he would make sure that Resident #2 took her medications.

Telephone interview with the Primary Care Provider (PCP) on 01/15/20 at 3:30pm revealed:
-She was not aware Resident #2's medication cup containing Cozaar 50 mg, Folic Acid 1 mg, HCTZ 12.5 mg, Xarelto 20mg, and Amiodarone 200mg daily was left by the MA in Resident #2's room on 01/12/20 and 01/13/20.
-Her expectation would be for the MA to administer the medications as ordered for Resident #2 and to be notified the same day of any missed medication doses.
-Her concerns were related to the missed doses of Xarelto and Cozaar due to Resident #2's medical history of A-Fib (an irregular, often rapid heart rate that can increase the risk of strokes, heart failure, and other heart-related complications).
-A major concern with Resident #2's was the potential to develop blood clots.
-The outcomes to Resident #2 due to missed medication doses were an elevated heart rate and the possibility of blood clots.
-The resident was on Xarelto as a preventive measure for blood clots.

Interview with the Pharmacy Consultant on 01/16/20 at 11:09am revealed:
-She was not aware Resident #2's medication cup containing Cozaar 50 mg, Folic Acid 1 mg, HCTZ 12.5 mg, Xarelto 20mg, and Amiodarone 200mg daily was left by the medication aide (MA) in Resident #2's room on 01/12/20 and 01/13/20.
-Medications should be administered to the residents as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 52	D 366		

-The MAs should witness the resident take the medications brought into the room.
-The PCP should be notified of any missed medication doses.
-Residents should not self-medicate without a physician's order.
-Due to the missed medication doses of Cozaar and Xarelto, she agreed with the Resident #2's PCP the outcomes to Resident #2 were an elevated heart rate and the possibility of blood clots.

Refer to interview with a family member for Resident #2 on 01/13/20 at 9:45am.

Refer to the interview with the Health and Wellness Director (HWD) on 01/13/20 at 3:52pm revealed.

Refer to the interview with the Executive Director (ED) on 01/13/20 at 4:38pm.

Refer to the interview with a family member for Resident #2 on 01/14/2020 at 8:35am.

e. Review of a physician order for Resident #2 dated 04/23/19 revealed Amiodarone (used in treatment of heart rhythm problems) 200mg daily.

Review of the January 2020 electronic medication administration records (eMARs) for Resident #2 revealed:
-There was an entry for Amiodarone (Pacerone) tab 200mg take 1 tablet by mouth once daily to be administered at 9:00am.
-There was documentation on 01/12/20 and 01/13/20 that Resident #2 was administered Amiodarone tab 200mg.

Interview with Medication Aide (MA) on 01/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 53 at 3:15pm revealed: -When administering medications to residents, she followed the physician orders on the electronic medication administration record (eMAR). -She would clean her hands and apply gloves. -She would make sure the resident was in the facility and awake. -If the resident was not available at the time of administration, she would dispose of the medications. -For Resident #2, she left her medications in her room on 01/12/20 and 01/13/20. -Resident #2's husband (Resident #4) made sure that Resident #2 took her medications. -Yesterday (01/12/20) Resident #4 told her to leave Resident #2's medications with him because Resident #2 was in the restroom or either asleep. -Today (01/13/20) she left Resident #2's medications with Resident #4 because Resident #2 was in the bathroom. -She was "comfortable" with leaving Resident #2's medications with Resident #4 because she knew that he would make sure that Resident #2 took her medications. Telephone interview with the Primary Care Provider (PCP) on 01/15/20 at 3:30pm revealed: -She was not aware Resident #2's medication cup containing Cozaar 50 mg, Folic Acid 1 mg, HCTZ 12.5 mg, Xarelto 20mg, and Amiodarone 200mg daily was left by the MA in Resident #2's room on 01/12/20 and 01/13/20. -Her expectation would be for the MA to administer the medications as ordered for Resident #2 and to be notified the same day of any missed medication doses. Refer to interview with a family member for	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 54 Resident #2 on 01/13/20 at 9:45am. Refer to the interview with the Health and Wellness Director (HWD) on 01/13/20 at 3:52pm revealed. Refer to the interview with the Executive Director (ED) on 01/13/20 at 4:38pm. Refer to the interview with a family member for Resident #2 on 01/14/2020 at 8:35am. Refer to the telephone interview with the PCP on 11/15/20 at 3:30pm. Refer to the interview with the Pharmacy Consultant on 01/16/20 at 11:09am. _____ Interview with a family member for Resident #2 on 01/13/20 at 9:45am revealed: -He was a resident of the facility. -He and the resident both shared a room. -The resident would get confused at times. -The resident had not eaten breakfast when the medication aide (MA) went to administer the resident's medications. -The resident liked to take her morning medications after breakfast. -The MA left the residents medications with him this morning to administer the medications to the resident because the resident had not yet eaten breakfast. -The MA would always leave the residents medications with him to administer to the resident if he was in the room when the MA was performing the medication pass. -The resident's medications in the cup were for the resident's memory, heart, thyroid, and osteoarthritis.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 55 Interview with the Health and Wellness Director (HWD) on 01/13/20 at 3:52pm revealed: -Prior to administering medications at the facility, the MA was required to complete the five and ten-hour or fifteen- hour training with register nurse (RN) consultation. -Her expectation for a MA when administering medications to a resident was for the MA to be visible and watch the resident take the ordered medications. -If a resident was in the bathroom during the time the MA came to administer their medications the MA should knock on the bathroom door and give the resident their medication. -If a resident was asleep during the time the MA came to administer their medications, the MA should wake the resident up and give the resident their medication. - The MAs should administer medications when they go to the residents' rooms because "they only have a that window of time" to give medications. -The MAs should also administer medications when they go to the residents' rooms because they are not going to remember to go back to the residents' room to give them their medication. -The MAs should not leave medications with residents because the resident may forget to take it. -The MAs also should not leave medications with residents because another resident could take it. Interview with the Executive Director (ED) on 01/13/20 at 4:38pm revealed: -His expectations for medication administration at the facility for the MAs were to administer medications for the correct resident, dosage, and route. -The MAs needed to supervise and witness the resident taking the medications as ordered.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 56	D 366		

-He expected the MA to wake up the resident if they were asleep to take the ordered medications.
-If a resident refused to take the medications while the MA was present in the resident's room, the MA was supposed to dispose of the medications and document the resident's refusal in the eMAR system.
-No resident's medications should be left in the room.

Interview with family of Resident #2 on 01/14/2020 at 8:35am revealed:
-Sometimes the MAs left Resident #2's medications with him for him to make sure that Resident #2 took them.
-He did not mind the MAs leaving Resident #2's medications with him.
-Sometimes medications were given to the residents beyond the 1-hour administration window.
-Resident #2 had to take her 8:00am medication before she could eat breakfast.

Telephone interview with the Primary Care Provider (PCP) on 01/15/20 at 3:30pm revealed:
-She was not aware Resident #2's medication cup containing Cozaar 50 mg, Folic Acid 1 mg, HCTZ 12.5 mg, Xarelto 20mg, and Amiodarone 200mg daily was left by the MA in Resident #2's room on 01/12/20 and 01/13/20.
-Her expectation would be for the MA to administer the medications as ordered for Resident #2 and to be notified the same day of any missed medication doses.
-Her concerns were related to the missed doses of Xarelto and Cozaar due to Resident #2's medical history of A-Fib (an irregular, often rapid heart rate that can increase the risk of strokes, heart failure, and other heart-related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 366	Continued From page 57 complications). -A major concern with Resident #2's was the potential to develop blood clots. -The outcomes to Resident #2 due to missed medication doses were an elevated heart rate and the possibility of blood clots. -The resident was on Xarelto as a preventive measure for blood clots. Interview with the Pharmacy Consultant on 01/16/20 at 11:09am revealed: -She was not aware Resident #2's medication cup containing Cozaar 50 mg, Folic Acid 1 mg, HCTZ 12.5 mg, Xarelto 20mg, and Amiodarone 200mg daily was left by the medication aide (MA) in Resident #2's room on 01/12/20 and 01/13/20. -Medications should be administered to the residents as ordered. -The MAs should witness the resident take the medications brought into the room. -The PCP should be notified of any missed medication doses. -Residents should not self-medicate without a physician's order. -Due to the missed medication doses of Cozaar and Xarelto, she agreed with the Resident #2's PCP the outcomes to Resident #2 were an elevated heart rate and the possibility of blood clots.	D 366		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 451	Continued From page 58 resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to notify the county department of social services (DSS) of accident or incident for 2 of 5 sampled residents (#3, #1) which resulted in referral for emergency medical evaluation and hospitalization for Resident #3 and referral for emergency medical evaluation and medical treatment for Resident #1. The findings are: 1. Review of Resident #3's current FL-2 dated 09/17/19 revealed: -Diagnoses included hypertension and diabetes. -The resident was ambulatory with a wheelchair. -The resident was incontinent of bladder and bowel. Review of the 24-Hour Communication Report dated 01/13/20 revealed: -Under the column titled, Falls, it was documented Resident #3 had a fall at 6:00am. -Resident #3 refused transport to the Emergency Room (ER). -Resident #3 had no visible injuries. -Under the column titled, New Admits or Discharges, it was documented Resident #3 "out to ER." Review of Resident #3's record revealed there	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 451	Continued From page 59	D 451		

were no completed Incident/Accident Reports for review.

Review of Accident/Incident (A/I) reports to the county DSS provided by the adult home specialist (AHS) on 01/16/20 revealed:
-There was a fax cover sheet dated 08/27/19.
-There was documentation of a resident's A/I information on the fax cover sheet dated 08/27/19.
-There were no A/I reports after 08/27/19.

Observation of Resident #3 on 01/13/20 at 11:05am revealed:
-The resident was awake laying on his bed.
-The resident was being assessed by EMS staff.
-The resident had difficulty moving his left leg with transfer to the EMS stretcher.
-The residents' legs were lifted and placed on the stretcher by EMS.

Telephone interview with a nurse at a local hospital on 01/13/20 at 5:25pm revealed Resident #3 had been admitted to rule out a stroke.

Telephone interview with Resident #3's Power of Attorney (POA) on 01/14/20 at 8:40am revealed:
-She was called by the MA on 01/13/20 at 10:59am and told the resident was found on the floor, later complained of tingling in his arm, and EMS was called.
-She saw the resident in the hospital 01/13/20 and he told her he "felt weird" on the night of 01/12/20, could not grab things, slipped off his bed, and vomited.
-The resident was confused with slurred speech in the hospital on 01/13/20.

Telephone interview with second nurse at a local hospital for Resident #3 on 01/14/20 at 9:10am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 451	Continued From page 60 revealed: -Resident #3 had left facial droop and left side weakness. -Resident #3 was being evaluated for a stroke. -Additional information could not be disclosed. Review of a local hospital emergency department note for Resident #3 dated 01/13/20 revealed: -The resident fell from bed around 6:00am today (01/13/20) -The resident arrived at the emergency department as a code stroke/trauma alert. -The resident arrived at the emergency department with left arm weakness and left facial droop. -The resident had slurred speech. -The resident was leaning to the left side. -The resident had a soft tissue contusion to the back of the head. (A contusion is a bruise often sustained from a blunt force such as a fall, or blow. The result is pain, swelling, and discoloration because of bleeding into the tissue.). Review of a local hospital history and physical provider note for Resident #3 dated 01/13/20 revealed: -The resident was transported to the emergency department as a "Code Stroke". -The resident was outside the window to receive TPA. -The resident's blood pressure was 192/93 (Normal blood pressure is less than 120/80). -The resident had hypertension in the setting of probable new stroke. -The resident had left sided facial droop and left-hand grip weakness with decreased coordination. -The resident was admitted for acute left sided weakness and slurred speech.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 451	Continued From page 61 Interview with the Adult Home Specialist (AHS) on 01/16/20 at 11:03am revealed the AHS did not receive an Incident/ Accident Report related to Resident #3's fall and subsequent hospitalization. Refer to interview with the Adult Home Specialist (AHS) on 1/16/20 at 11:03 a.m. Refer to the interview with the Health and Wellness Director (HWD) on 01/16/20 at 2:34pm. Refer to the interview with the Executive Director (ED) on 01/16/20 at 4:00pm. 2. Review of Resident #1's current FL-2 dated 12/19/19 revealed diagnoses to include syncope, orthostasis, acute cystitis without hematuria, dementia, diabetes mellitus type II, chronic diastolic congestive heart failure, chronic kidney disease stage III, blindness of the right eye with category 3 blindness of the left eye, essential hypertension, old cerebral vascular accident with cognitive deficits. Review of Resident #1's discharge summary dated 12/30/19 revealed Resident #1 had an episode of "hypotension with minimal responsiveness" and was sent out by the facility to theemergency room (ER) via emergency medical services (EMS). Review of Resident #1's discharge summary dated 01/06/20 revealed: -Resident #1 was found slumped over in her dining room chair by facility staff. -Chest compression was performed by staff after they thought Resident #1 was not breathing and she woke up after a few compressions. -Resident #1 was sent out to the ER via EMS and	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 451	Continued From page 62 was diagnosed with a urinary tract infection without hematuria, site unspecified with decreased responsiveness. Review of Resident #1's discharge summary dated 01/09/20 revealed: -Resident #1 was sent out to the ER via EMS after an unwitnessed fall out of her wheelchair. -Resident #1's chief complaint was trauma alert, fall when she presented to the ER. -Her discharged diagnoses included closed head injury, initial encounter and traumatic hematoma of forehead, initial encounter. Review of Resident #1's records revealed there were no completed Incident/Accident Reports for review. Review of A/I reports to the county DSS provided by the AHS on 01/16/20 revealed: -There was a fax cover sheet dated 08/27/19. -There was documentation of a resident's A/I information on the fax cover sheet dated 08/27/19. -There were no A/I reports after 08/27/19. Several request to facility on 1/14/20 through 1/16/20 for their last four months of accident and incident reports, including those for Resident #3 and Resident #1, were not provided to the survey team by the survey exit date of 1/16/20. Interview with the Adult Home Specialist (AHS) on 1/16/20 at 11:03 a.m. revealed the AHS had not receive an Incident/Accident report related to Resident #1 fall and ER visit on 01/09/20. Refer to interview with the Adult Home Specialist (AHS) on 1/16/20 at 11:03 a.m.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 451	Continued From page 63 Refer to the interview with the Health and Wellness Director (HWD) on 01/16/20 at 2:34 p.m. Refer to the interview with the Executive Director (ED) on 01/16/20 at 4:00 p.m. _____ Interview with the Adult Home Specialist (AHS) on 01/16/20 at 11:03am revealed: -An Incident/Accident report dated 08/27/19 was reported to the AHS. -The 8/27/2019 report was related to a resident's fall. -An Incident/Accident Report dated 07/24/19 was reported to the AHS. -The 07/24/19 report was related to a resident's fall. -An Incident/Accident Report dated 04/30/19 was reported to the AHS. -The 4/30/2019 report was related to a resident's fall. -No other Incident/Accident reports had been reported to the AHS since the report was submitted on 8/27/2019. Interview with the Health and Wellness Director (HWD) on 01/16/20 at 2:34pm revealed: -When an accident/incident (A/I) occurred, the Supervisor (S) should assess the situation and resident. -It was the facility procedure for the Supervisor to call EMS and the resident's family. -It was facility procedure to contact a resident's physician, and to notify the county DSS when a resident was transported by EMS to the hospital within 48 hours of the incident/accident. -It was facility procedure to complete an Accident/incident Report at the time of occurrence. -The staff member notified of an incident or the	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 451	Continued From page 64 Supervisor on duty for that shift is responsible for completing the A/I Report. -The HWD was responsible for notifying the county DSS of the A/I by faxing the A/I Report to DSS within 24 hours. -The Resident Care Coordinator (RCC) would notify the county DSS in the HWD's absence. -The HWD had asked the Supervisor/Medication Aide (S/MA) to complete the A/I report for Resident #1 while she was out of the office for training, but it had not been done yet. -The HWD assumed the A/I report for Resident #1 had been completed by the S/MA and did not follow up to ensure the report was completed. -The A/I Report had not been faxed to the county DSS because the report had not yet been completed by the S/MA. -Paper A/I reports had been completed and faxed to DSS up until one week ago. -Fax cover sheets had been used to document A/I reports and send to DSS up until one week ago. -The facility switched to electronic A/I reports one week ago. -The electronic A/I reports would not print. -She did not know the last time an A/I report was sent to DSS. -She could complete the A/I reports on a fax cover sheet and send to DSS until the electronic A/I reports could be printed. -Due to the facility's new documentation system related to incident and accident reporting, she did not know how to print the incident/accident documentation to send to the county DSS. -There was no current system in place to print form and send form to county DSS. Interview with the Executive Director (ED) on 01/16/20 at 4:00pm revealed: -When a resident accident/incident (A/I) occurred,	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 451	Continued From page 65 the personal care aide (PCA) should report it to the Supervisor (S). -The Supervisor would document the resident's A/I in the 24-hour communication log. -The HWD should check the 24-hour communication log daily for any resident involved A/Is documented. -The supervisor should check the 24-hour communication log on the weekends for any resident involved A/Is documented. -The HWD would complete all A/I reports in the facility's electronic documentation system. -The HWD was the only one responsible to complete the A/I reports. -The S would complete the A/I reports only if the HWD was not present. -Management would participate in a 24-hour stand up meeting to discuss all resident care concerns. -If an A/I was not reported it should have been discovered during the 24-hour stand up meeting. -If an A/I was discovered during the 24-hour stand up meeting then a A/I report would be completed and sent to DSS. -The A/I reports were sent to DSS so they could investigate the A/I to ensure residents were safe. -He expected all A/I reports be sent to the county DSS representative within 24-hours and to place the fax confirmation within the chart. -He did not answer when asked if he was aware of any incidents/accidents that occurred recently and had not been reported to the county DSS.	D 451		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
D912	Continued From page 66 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure residents received care and services that were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to housekeeping and furnishings and medication administration. The findings are: 1. Based on observations and interviews, the facility failed to assure the facility was free of hazards as evidence by storage of multiple portable oxygen (O2) cylinders in an unsafe manner, on the floor not secured in racks or crates, in 2 residents' rooms and transporting by propping in resident rollators while in use. [Refer to Tag 079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's medication policies for 1 of 6 residents (#8) observed during the medication passes including errors with a cardiac medication and a vitamin supplement. [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation)].	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092166	A. BUILDING: _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
D914	Continued From page 67	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were provided with the necessary care and services to maintain their physical and mental health as related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for 2 of 5 sampled residents (#1, #3) who (#3) sustained an unwitnessed fall, had vomited, and was incontinent of stool who later developed tingling and weakness of his left hand and legs; and a resident (#1) received referral for Physical and Occupational Therapy. [Refer to Tag 273 10A NCAC 13F .1004(a) Health Care (Type A1 Violation)].	D914		