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	HAL026056	A. BUILDING: _____ B. WING _____	C 04/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF FAYETTEVIL	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on April 14-17, 2015.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record review, interviews and observations, the facility failed to provide adequate supervision on the Special Care Unit (SCU) in accordance with each resident's needs, care plan and current symptoms for 2 of 5 sampled residents; two residents who were at risk for wandering and one of the two residents was at risk for falls. (Resident #1, #2). The findings are: 1. Review of Resident #1's current FL-2 dated 1/21/15 revealed: -Diagnoses included vascular dementia, coronary artery disease, osteoporosis, hypertension (HTN), pernicious anemia and vitamin deficiencies. -Resident #1 was documented as a wanderer. Review of Resident #1's current Care Plan dated 1/27/15 revealed: -Documented under "Orientation" was sometimes disoriented.	D 270		

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D 270	Continued From page 1 -Documented under "Memory" forgetful-needs reminders. Review of the facility's Incident Report dated 3/20/15 (no time) revealed: -The facility's nurse was notified on 3/20/15 at 6:15 a.m. by the Assisted Living Unit/Special Care Unit (ALU/SCU) supervisor that Resident #1 was lying on the floor in the bathroom dead. -The personal care aide (PCA) found the resident lying on the floor in the bathroom in blood on 3/20/15 (no time). -The facility's nurse no longer worked at the facility. Review of the police officer's "Case Supplemental Report" dated 3/20/15 at 6:09 a.m. documented: -The officer responded to the facility on 3/20/15 at 6:09 a.m. in reference to a sudden death. -Resident #1 was laying on her left side near the entrance to the shower. -Her feet were almost touching the threshold of the door. -Her left leg was bent and her right leg was straight. -Her hands were up near her face. -Face had apparent blunt trauma to the nose and mouth area and extensive bleeding. -Pooling had already set on her face. -There was blood on the floor by her face and in the shower. -"Blood drops were on the ground under the sink." -"There was a white plastic hamper under the sink that had blood on the top where it looks to be where she grabbed it to pull herself up." -She was wearing a floral nightgown and white socks. -"There was blood all on the floor in the	D 270		

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D 270	Continued From page 2	D 270		

bathroom."
- "The blood on the floor was dry leading to the possibility that [Resident #1] had been laying on the floor since before [personal care aide] discovered her body."

Review of the "Case Supplemental Report" scene conditions dated 3/20/15 documented:
- "Rigor mortis was not present however slight livor mortis was present and was constant with the position of the body."
- "No defensive type wounds were found."

Review of Resident #1's death certificate dated 4/26/15 (no time) revealed resident's caused of death was blunt forced head injury due to a fall.

Telephone interview with the police officer on 4/17/15 at 2:00 p.m. revealed:
-Personal Care Aide (PCA) reported that her shift began at 11:00 p.m. on 3/19/15.
-PCA looked into Resident #1's room on 3/20/15 at 3:00 a.m. and noticed that resident's bed sheets were pulled back.
-PCA believed Resident #1 was using the restroom on 3/20/15 at 3:00 a.m.
-PCA did not walk into Resident #1's room.
-PCA stated "They do not like it when we go in their rooms and bother them."
-PCA could not be sure if Resident #1 had already fallen on 3/20/15 at 3:00 a.m.
-PCA began her last round on 3/20/15 at 5:30 a.m.
-The same PCA discovered Resident #1 on the floor in the bathroom on 3/20/15 at 6:00 a.m.and blood was all over the floor in the bathroom.

The same personal care aide (PCA) who was responsible for the care of Resident #1 on 3/19/15 (11:00 p.m.-7:00 a.m.) was not available

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D 270	Continued From page 3 for interview by person or phone. Telephone interview with Resident #1's family member on 4/14/15 at 7:59 p.m. revealed: -The family member was notified on 3/20/15 at 7:00 a.m. by the facility's nurse that Resident #1 had fallen and passed away. -The nurse stated, "[Resident #1] was checked by personal care aide (PCA) on 3/20/15 at 2:00 a.m. and the bathroom door was closed. -The nurse stated, PCA did not actually see [Resident #1] at 2:00 a.m. -The nurse stated, PCA did not make another round until 6:00 a.m. on 3/20/15. -The same facility's nurse no longer worked at the facility. Interview with the Assisted Living Unit/Special Care Unit (ALU/SCU) Supervisor on 4/16/15 at 6:20 a.m. revealed: -She was notified by a personal care aide on 3/20/15 at 6:00 a.m. that something was wrong with [Resident #1]. -She immediately went back to the SCU. -She did not know what she was walking into. -She knelt beside Resident #1 and felt for a pulse. -Resident #1 was cold. -Personal care aide (PCA) stated she checked on Resident #1 between 2:00 a.m. and 3:00 a.m. on 3/20/15. -She did not ask the PCA, if Resident #1 was in the bed or bathroom. -PCA stated she checked on Resident #1 on 3/20/15 at 6:00 a.m. and Resident #1 was lying on the bathroom floor and blood was all over the floor. -PCA stated, "She did not check on Resident #1 as frequently as she should have."	D 270		

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D 270	Continued From page 4 -Resident #1 was able to go to the bathroom independently. -PCA stated she saw Resident #1 alive in her room on 3/20/15 between 2:00 a.m.-3:00 a.m. -The supervisor stated, "All residents should be checked every 2 hours for safety and toileting issues." -The supervisor stated, "That is common knowledge that residents should be checked every 2 hours." Interview with the Memory Care Coordinator on 4/17/15 at 1:30 p.m. revealed: - Resident #1 wandered into other residents' rooms. -All residents should be checked at least every 2 hours. Interview with the Administrator on 4/16/15 at 10:00 a.m. revealed: -She was notified by the Assisted Living Unit/Special Care Unit (ALU/SCU) (11:00 p.m. -7:00 a.m.) supervisor on 3/20/15 at 7:30 a.m. that Resident #1 had fallen and passed away. -The Administrator did not tell the supervisor to do anything differently because she was already following the facilitiy's protocol following a resident's death. -Personal care aide (PCA) assigned to Resident #1 on 3/19/15 (11:00 p.m.-7:00 a.m.) stated she checked on Resident #1 between 2:00 a.m.-3:00 a.m. on 3/20/15. -PCA stated Resident #1 was in the bathroom between 2:00 a.m. 3:00 a.m. on 3/20/15. -PCA stated she talked to Resident #1 through the door between 2:00 a.m.-3:00 a.m. on 3/20/15. -She did not asked PCA the last time she actually laid eyes on Resident #1. -PCA stated Resident #1 did not like people in the bathroom with her.	D 270		

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D 270	Continued From page 5 -Resident #1 liked her privacy. -PCA stated she did not make 2 hours checks because she was tied up with other residents who required more care. -PCA should have notified the Supervisor and asked for help, if she could not make her rounds. -PCA should have followed proper protocol which was residents should be checked every 2 hours. 2. Review of Resident #4's current FL-2 dated 1/21/15 revealed: -Diagnoses included Alzheimer's dementia, craniotomy/hematoma, hypertension, and mastectomy. -The resident was constantly disoriented, wandered, and needed assistance with bathing and dressing. -The resident resided in the special care unit (SCU). Review of Resident #4's Care Plan dated 6/28/14 revealed: -The resident was residing in the SCU for safety. -The resident needed assistance with meals, bathing, dressing, toileting, and monitoring during transferring for safety. Observation on 4/14/15 at 4:15 pm revealed Resident #4 was seated in the SCU lounge area with other residents. Observation on 4/16/15 at 11:55 am revealed Resident #4 was seated at a table in the SCU dining room with a rollator (4-wheeled rolling walker with a seat) positioned beside her. Review of the Licensed Health Professional Support (LHPS) assessment dated 4/7/15 revealed: -Resident #4 tasks included ambulation using	D 270		

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D 270	Continued From page 6 assistive devices that requires physical assistance (walker). -The resident wore glasses. -The resident had a chair alarm. Review of the Quarterly Pharmacy Review documentation for Resident #4 revealed: -Visit for 12/2/14 revealed documentation of dates of 9 previous falls. -The resident had leg cramps. -Physical therapy was ordered. -Hipsters (a padded brief worn to provide cushioning for the hips in case of a fall) were ordered. Review of the facility's Accident Reports and local hospital records from 11/19/14 to 3/31/15 for Resident #4 revealed: -On 11/9/14 at 2:10 pm, staff heard the resident's alarm and found the resident lying face down on the floor. The resident had a "small bruise under the left eye and complained of right leg pain. The resident did not hit her head."The resident was assisted to her recliner and was administered Tylenol for pain. (The resident was not sent to the hospital). -On 11/19/14 at 1:40 pm, the resident was observed lying on the floor in front of her dresser, and complained of head pain. The resident was sent via ambulance to a local hospital. -On 11/19/14 the resident was admitted at 2:24 pm at a local hospital for fall injury with complaint of hurting all over, right hip and right shoulder pain. Discharge diagnoses of fall, mild concussion, cervical strain, contusion. - (No facility Accident Report available for12/14/14 for Resident #4)	D 270		

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D 270	Continued From page 7 -On 12/14/14 the resident was admitted at 5:05 am for fall injury with complaints of continuous back and left hip pain. Discharge diagnoses of fall with lumbago and contusion, head. -On 2/7/15 at 12:30 pm, the resident was observed lying on the floor, complained of back pain and of hitting her head. The resident was sent via ambulance to a local hospital. -On 2/7/15 the resident was admitted at 1:22 pm at a local hospital for fall injury and complaint of pelvic and bilateral hip pain. Discharge diagnosis of fall injury. - (No facility Accident Report available for 2/27/15 for Resident #4) -On 2/27/15 the resident was admitted at 1:22 pm at a local hospital for fall injury with pelvic and hip pain. Discharge diagnosis of fall injury. -On 3/1/15 at 10:55 am, the resident was found lying on her left side on the floor and stated she hit her head and complained of right arm and back pain. The resident was sent via ambulance to a local hospital. -On 3/01/15 the resident was admitted at 11:50 am at a local hospital for fall injury. Assessment of high falls risk due to history of recent falls and weakness. -On 3/3/15 at 3:25 pm, staff observed resident lying near the foot of her bed complaining of pain in both hips, back, and head. Resident stated she slipped and fell in the bathroom. The resident was sent via ambulance to a local hospital. -On 3/03/15 the resident was admitted at 4:36 pm at a local hospital for fall injury pain with diagnosis of contusion to the head and hip. -On 3/4/15 at 4:00 pm, the resident was observed	D 270		

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D 270	Continued From page 8 lying on the floor, complained of hitting her head and pain in her left leg. The resident had trouble bearing weight on the leg. The resident was sent via ambulance to a local hospital. -On 3/04/15 the resident was admitted at 5:47 pm at a local hospital for fall injury with left knee pain. Wound on left knee. Discharge diagnoses of contusion face, neck and scalp, abrasion leg. -On 3/10/15 at 6:54 pm, the resident fell while attempting to transfer from the wheelchair into an armchair making the chair alarm sound. "Staff directed to monitor the resident." -On 3/14/15 at 1:15 pm, staff heard the resident's chair alarm and observed the resident sitting on the floor and having no complaints of pain at that time. -On 3/19/15 at 11:30 am, the medication aide heard the resident hollering for help. The resident was observed lying on the floor beside the bed saying she fell coming out of the bathroom and hit her head and complained of arm, back, and leg pain. The resident was sent via ambulance to a local hospital. -On 3/19/15 the resident was admitted at 12:23 am at a local hospital for fall injury with shoulder/arm pain and contusion of the scalp. Discharge diagnosis of contusion scalp. -On 3/23/14 at 9:00 am, the resident tripped over carpeting and hit her head and lower right leg. The resident was sent via ambulance to a local hospital. -On 3/23/15 the resident was admitted at 9:50 am at a local hospital for fall injury. Discharge diagnosis of closed head injury, no loss of consciousness.	D 270		

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D 270	Continued From page 9 -On 3/31/15 at 12:25 pm, the resident fell out of her wheelchair hitting her head and complaining of pain. The resident was sent via ambulance to a local hospital. -On 3/31/15 the resident was admitted at 1:16 pm at a local hospital for fall injury, complaint of right leg, back and right trunk pain, fall out of wheelchair hitting head on floor. Pt. in cervical collar. Discharge diagnosis of injury, elbow, arm, wrist; soft tissue edema. Interview on 4/14/15 with a 1st shift SCU PCA revealed: -Routine monitoring checks (visually seeing the resident) were done every 2 hours; residents who were a falls risk were checked every 15 minutes. -Staff tried to keep the SCU residents involved in activities and keep the residents where staff could see them. -The protocol for a resident with a head injury was to yell out for help, keep the resident still, and get the medication aide (MA). -The supervisor or the MA made the call for the EMS. Interview on 4/15/15 with a 1st shift SCU MA revealed: -Resident #4 was a falls risk and was monitored every 15 minutes. -Staff tried to keep the resident active and out of her room. Interview on 4/15/15 with a 2nd shift SCU PCA revealed: -The SCU residents who were a falls risk were monitored every 30 minutes. -Staff tried to keep the residents involved in activities. Interview on 4/16/15 with a 3rd shift SCU PCA	D 270		

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D 270	Continued From page 10 revealed: -Residents who are a falls risk are monitored every 30 minutes if awake and every hour if asleep. -If a resident was not in bed, staff would check in the resident's bathroom by calling and walking into the room. -Staff was trained to check on residents every 2 hours. Interview on 4/15/15 at 3:00 pm with the 1st shift SCU Coordinator revealed: -Resident #4 had lots of falls, the last one occurred about 7-9 days ago. -A system of monitoring was in place for the resident. Interview on 4/17/15 at 3:45 pm with the 2nd shift SCU Coordinator revealed: -Falls risk residents' monitoring may be more frequent than every 2 hours. -Monitoring residents in their rooms could vary from every 10 minutes and up. -Sometimes the family was called to arrange a sitter for a resident. -A plan was in place for Resident #4 for falls; care conferences were held quarterly with the Executive Director, Resident Care Director, and the SCU Coordinators. -Resident #4's Power of Attorney and Physician were asked for suggestions. -The Coordinator was not aware of any medication changes related to the resident's falls. -The nurse was responsible for changing the resident's care. -Resident #4 had a bed/chair alarm and wore hipsters. -The resident was discouraged from staying in her room. -Resident #4 did not like to participate in	D 270		

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D 270	Continued From page 11 activities, but would sit and listen. -When Resident #4's legs were weak, she would use the wheelchair instead walking with the rollator. -For fall prevention, all staff observed Resident #4 for signs of weakness and having falls. -The Coordinator was "not familiar with a routine for falls outside of what we are doing; not familiar with a company falls policy." -The Coordinator stated having "a conversation with Resident #4's family about being able to meet the resident's needs" and "know that the family is taking the resident to another facility." Interview on 4/17/15 at 10:57 am with Resident #4's Power of Attorney (POA) revealed: -The POA visited Resident #4 at the facility at least once a week and called often. -Resident #4 had "a fractured wrist and tail bone sprains since she had been in the facility". -After the tailbone fracture several months ago (late fall 2014), the nurse asked the family to get a chair alarm. -The POA was told staff checked on the residents at shift change. -Resident #4 had spells of falling and did not know how often staff checked on her. -The POA stated receiving a call from the facility after midnight several months ago (could not remember date), reporting the resident had a fall. -Staff reported using the bed/chair alarm, but had the resident's room door closed and did not hear the alarm except when walking directly past the room door. -The POA stated Resident #4's room was close to the middle of the SCU where the staff sat and the staff should have been able to hear the alarm as the alarm was loud. -The resident "made 6 visits to the hospital last month; she could not have that many falls without	D 270		

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D 270	Continued From page 12 injury". -The POA stated "the facility where Resident #4 will be moving, she will be checked every 15 minutes." Record review for Resident #4 revealed: -Frequent Fall Notification and Review Requests dated 11/12/14, 12/17/14, and 4/1/15. -Falls documented included 13 for the past 6 months and 10 for the past 3 months. -Falls in the month of March 2015 were documented as occurring on the 1st, 3rd, 7th, 10th, 14th, 19th, 23rd, 27th and 28th. Interview on 4/17/15 at 10:32 am with Resident #4's Physician's nurse revealed: -On December 17, 2014 a Frequent Fall Notification for Resident #4 was received in the office from the facility documenting numerous falls covering a period of months (was not specific). -The office also received notification from the facility of Resident #4 falling and being sent to the hospital on March 3-4, 2015. -There were no additional Frequent Fall Notifications received for Resident #4 from the facility in the resident's records. Interview on 4/17/15 at 10:40 am with Resident #4's Physician's physician assistant (PA) revealed: -Resident #4's POA brought the resident into the office for follow-ups after hospitalizations for falls. -The resident had a chair alarm and physical therapy. -The PA stated "if the resident (#4) continued to fall, she needed a higher level of care or more supervision". -Resident #4's physician was unavailable for interview.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026056	A. BUILDING: _____ B. WING _____	C 04/17/2015

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D 270	Continued From page 13 When requested a copy of the Falls Policy, the facility provided the following documents: Emergency Procedures in the Event of a Fall, Post Fall Checklist, DSS (Department of Social Services) Report Instructions, Resident Agreement, DSS Accident Report Instructions, DSS Accident Report, and 24-Hour Post Fall Checklist. Interview on 4/17/15 at 4:30 pm with the facility's Regional Nurse revealed: -For the SCU, the facility did "the usual monitoring, they tried to keep residents involved in different activities." -If a resident was in their room, monitoring was every 2 hours. -Staff would go into the resident's room and go up to the resident. - If the resident was in the bathroom, staff would go back to the resident's room in 5, 10, 15, to 20 minutes to check on them, depending on the resident. -Resident #4 was a high falls risk and had a wheelchair, rollator, bed/chair alarm, and wore hipsters. -The bed/chair alarm was discontinued 4/16/15 by physician order, but did not specify reason. -Physical therapy had progressed Resident #4 from using the wheelchair to using the rollator. -For monitoring, the resident wore hipsters, used the rollator, was active, and was within sight of staff. -The resident was checked every 15 to 30 to 60 minutes. -"When (the facility) feels a concern about meeting Resident #4's needs, we will meet with (the family), and ask for suggestions." -Staff continued the plan (hipsters, having the resident in activities, using the wheelchair or	D 270		

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D 270	Continued From page 14	D 270		

rollator), and we looked to the physician for any changes and any input from the family.
-No changes have been requested for monitoring times from the family or the physician.
-The RN previously talked with the POA about having sitters for Resident #4.
-The facility did not have a Falls Policy.
-Resident #4 had a "higher functioning" roommate for her to copy behaviors.
-Resident #4 had nothing diagnosed of a physical nature for falls, only a mental change.

Confidential interview revealed:
-Staff checked on Resident #4 while making rounds every 1-2 hours, 3-4 times during the day.
-The resident was a falls risk and should be checked on every 15 minutes.
-After each fall, staff had continued the same monitoring for the resident.
-There had not been any changes in the monitoring, nothing new was put in place.
-If something different was to be done for the care of the resident, the nurse or the coordinators would have let staff know.

Confidential interview revealed:
-The SCU monitoring routine monitoring for residents was every 2 hours.
-For a falls risk resident, staff should monitor more often than every 2 hours; 5 to 15 to 45 minutes depending on the resident.
-Resident #4 had a chair alarm and a walker.
-When the resident had leg weakness or arthritis problems in her left knee, back or all over, she would use a wheelchair.
-If the resident was lying down, staff were to keep the door open so they would be able to hear the chair alarm.
-For Resident #4, staff was instructed to "keep eyes on her; the instructions were the same after

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D 270	Continued From page 15 each fall, no changes were made." -The resident had not fallen in about 2 weeks. -Did not know if there was a facility falls policy or procedure, the plan for staff for Resident #4 was to watch and monitor more than every 2 hours. Interview on 4/17/15 at 5:40 pm with the Executive Director revealed: -Resident #4 had behaviors, she wanted to go home. -The resident's POA, physician, and family were aware of all of the falls. -For monitoring the resident - she had hipsters and a bed/chair alarm. -The resident was now using a rollator and not using the wheelchair for mobility. -The resident was "kept in activities and staff is doing 2 hr. checks and as often as possible." -We had conferences with the family. -The facility did not have a Falls Policy outlining procedures for falls prevention. -The physician and family were notified of the falls and talked with on a regular basis; it was a group effort. - "Resident #4) is advanced in her dementia, you get to a point where you have watched her as much as we can. - (Resident #4) is declining, have seen her decline. - (Resident #4) has had a significant change in the last 4 months." _____ A plan of protection was requested by this office. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 17, 2015	D 270		

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D912	Continued From page 16	D912		
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 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on record review, interviews and observations, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on record review, interviews and observations, the facility failed to provide adequate supervision on the Special Care Unit (SCU) in accordance with each resident's needs, care plan and current symptoms for 2 of 5 sampled residents; two residents who were at risk for wandering and one of the two residents was at risk for falls. [Refer to Tag D 270 10 A NCAC 13F .0901(b) (Type A1 Violation)].	D912		