STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049031	A. BUILDING: _____ B. WING _____	04/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF MOORESVIL	198 E WATERLYNN RD MOORESVILLE, NC 28117

(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 an annual survey on 4/29/15 and 4/30/15.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (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: TYPE B VIOLATION Based on observation, record review and interviews, the facility failed to implement infection control measures ordered by the physician for 1 of 1 residents (Resident #4) with Clostridium difficile (C. diff.). The findings are: Review of Resident #4's FL-2 dated 06/03/14 and verified by the facility on 09/18/14 revealed: - Diagnoses included chronic pain, macular degeneration and muscle weakness. - The Resident was continent of bowel. Review of Resident #4's care plan dated 09/18/14 revealed the Resident received limited assistance with toileting. Review of progress notes in Resident #4's record	D 276		

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D 276	Continued From page 1 for the period of 03/27/15 through 03/28/15 revealed complaints of loose stool, vomiting and stomach pain. Review of a progress note in Resident #4's record dated 03/28/15 at 11:30 AM revealed the Resident requested to be sent to the hospital. Review of a hospital history and physical report dated 03/28/15 revealed: - Admission to the hospital for management of vomiting and diarrhea, likely with an infectious etiology. - A plan to obtain a stool specimen for culture and check for C. diff. Review of a hospital discharge medication reconciliation form dated 03/31/15 revealed: - A discharge prescription for a probiotic (a supplement containing microorganisms that aid in the treatment of infectious diarrhea), one capsule every 8 hours. - A discharge prescription for metronidazole (an antibiotic used in treating infection of the colon caused by C. diff.), 500 mg dose, three times a day for 2 weeks Review of a Licensed Health Professional Support (LHPS) nurse note dated 04/02/15 revealed: - The physician ordered metronidazole 500 mg for a positive C. diff laboratory result. - Resident #4 was placed on "precautions" and was staying in her room until follow-up. Review of Centers for Disease Control and Prevention (CDC) 2007 edition of "Guideline for Isolation Precautions Preventing Transmission of Infectious Agents in Healthcare Settings" revealed the following information and	D 276		

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D 276	Continued From page 2	D 276		

recommendations for the management of C. diff.:
- C. diff. is considered an "epidemiologically important organism" due to its "propensity for transmission within healthcare facilities ..."
- Important factors that contributed to healthcare-associated outbreaks included "and carriage by healthcare personnel to other patients..."
- "Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment."
- Prevention of transmission is focused on implementing Contact Precautions for patients with diarrhea and consistent hand hygiene by use of "soap and water, rather than alcohol based handrubs," for mechanical removal of spores from hands.

Review of facility policy titled "Infection Control Contact Precautions Protocol" (revision date of April 2013) revealed:
- "A contact isolation sign will be placed on both sides of the bathroom door to maintain resident privacy."
- "Hands will be washed immediately with hand sanitizer prior to leaving the room."
- "Paper Towels and hand soap to be kept in resident's bathrooms. All staff will wash hands per [facility's] Hand Washing Procedure prior to leaving resident's room."
- "If coughing, drainage or incontinence is present, resident will be served meals in room using disposable plates, cups and utensils."

Review of All Staff Meeting minutes dated 04/02/15 revealed:
- The Executive Director (ED) and another unidentified person were speakers

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D 276	Continued From page 3 - A topic item was "Contact Precautions" by an unidentified person with no further elaboration. - A topic item was "Resident Care- Handwashing" with no further elaboration. - A staff roster with printed names and signatures was attached documenting attendance by the Dining Service Director (DSD), Supervisor-in-Charge (SIC) #1 and Personal Care Aide (PCA) #1. Review of physician orders dated 04/13/15 revealed Contact Precautions were to be continued for 7 days after completion of the antibiotic then stopped. Review of Resident #4's medication administration record for the month of April, 2015 revealed the 2 week course of metronidazole was completed on 04/14/15. Review of progress notes in Resident #4's record for the period of 04/15/15 through 04/22/15 revealed the Resident complained of diarrhea and receiving the medication loperamide (used in the treatment of diarrhea) with effective results. Review of a physician order signed 04/23/15 revealed Resident #4 was to have a stool study for WBC (white blood cells) and C. diff. Review of progress notes in Resident #4's record for the period of 04/23/15 through 04/28/15 revealed: - Staff were unable to obtain a stool specimen with the Resident reporting she was unable to go to the bathroom. - A note on 04/26/15 documenting a stool specimen was obtained and sent to the laboratory.	D 276		

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D 276	Continued From page 4 Observation on 04/29/15 at 10:20 AM revealed: - The door to Resident 4's room was open. - Other than the room number and name plate adjacent to the door frame in the hall, there were no other signs or notices on or adjacent to the door and the state surveyor entered the Resident's room with no additional precautionary measures. Interview on 04/29/15 at 10:20 AM with Resident #4 revealed: - She recently was sick, had diarrhea and was hospitalized. - All meals recently had been delivered to her room due to illness and that she ate breakfast that day in her room. - Staff were asking her to remain in her room. Observation of Resident #4's room on 04/29/15 at 10:25 AM revealed: - A Contact Precaution sign taped to the inside of Resident #4's bathroom door, open to and visible in the Resident's room. - A yellow plastic bag with a biohazard symbol printed on it, sitting on the floor, tied shut and containing unidentified items. - A plastic container with drawers, sitting next to the yellow plastic bag and containing yellow disposable gowns and boxes of gloves. - A non-disposable circular brown tray with a white non-disposable china dining plate, placed on her dresser under her television. The plate contained crumbs of food and was partially covered with a green plastic dome. Metal flatware was on the tray. - Personal hygiene products placed around the bathroom sink but no hand soap for staff or state surveyor use (the state surveyor left the room without touching anything and washed hands with soap and water in a common restroom in the	D 276		

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D 276	Continued From page 5 hallway). Interview on 04/29/15 at 10:45 AM with the DSD revealed: - All residents ate in the main dining room unless they were ill in which case their meals were delivered to their rooms. - At the time only one resident was being served her meals in her room, she recently returned from the hospital and [Resident #4's name] was mentioned. Observation on 04/29/15 at 12:30 PM revealed: - The DSD and Supervisor #1 taking a plate of food from the main dining room to Resident #4's room, leaving the door to the Resident's room open. - A new Contact Precaution sign was taped to the closet door located just inside the doorframe to Resident #4's room. - Upon completion of conversation with the Resident (overheard through the open door) about her lunch, the DSD and Supervisor #1 immediately left Resident #4's room, without any handwashing, and walked down the hall back towards the main dining room without stopping along the way to wash their hands. - In Resident #4's room resting on her dresser was observed a circular black plastic plate with a sandwich and metal spoon. Interview on 04/29/15 at 2:00 PM with the DSD revealed: - Resident #4 had "stomach issues" and had been having meal trays delivered to her room for a "week or so." - Her meals were served on plastic disposable plates, on Styrofoam and with plastic disposable cutlery. - When she delivered lunch to Resident #4 she	D 276		

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D 276	Continued From page 6 put the tray down, she did not touch anything and she washed her hands in the hand washing sink located in the kitchen. - She did not think staff would wash their hands in resident's bathrooms as staff would not want to "touch stuff" and she was not sure how they would do this. - Staff had their own personal containers of hand sanitizer and it was also located in the hallways. - "Nurses" had told staff how to wash their hands. Interview on 04/29/15 at 2:15 PM with Supervisor #1 revealed: - Resident #4 was diagnosed with C. diff. and has refused to provide a stool specimen. - After care was given, hands were washed then hand sanitizer was used. - Staff had hand sanitizer on their person at all times and she motioned to a bottle of hand sanitizer hanging off her uniform. - She had "always" washed her hands outside of the resident's room, using bathrooms in the hallway, the sink behind the desk or the sink next to the medication cart. - Resident #4 was on precautions with signage on the bathroom door and closet door. - Resident #4 was the first resident in the facility who had been placed on any type of isolation. - Staff received infection control training when they were first hired but she was not sure if they received refresher or update training. - After delivering the Resident's lunch plate she washed her hands in the hand washing sink in the kitchen, using her elbow to push open the kitchen door. Interview on 04/29/15 at 5:00 PM with Personal Care Aide (PCA) #1 revealed: - She was assigned to Resident #4's hall and was knowledgeable about the Resident's care needs.	D 276		

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D 276	Continued From page 7 - She was told that Resident #4 had C. diff. - The Resident was not incontinent and only occasionally called for assistance to and from the bathroom. - The previous week the Resident's stool was loose but since then the Resident had not asked the PCA for help. - After resident care was completed, she would peel off the gloves and wash her hands in the sink at the staff desk on the A and B units or at the nearest sink. - She did not wash her hands in the resident's room. - She received training on isolation measures. Interview on 04/29/15 at 4:25 PM with the Resident Care Coordinator revealed: - Resident #4 was on precautions and had C. diff. - Staff could wash their hands in the resident's bathroom if they wanted, or could sanitize them and wash their hands at the sink at the staff desk on the A and B units or in the bathroom in the hall. - Soap and towels would have to be placed in the resident's bathroom in order to wash hands there. - The hospital alerted the facility that Resident #4 was diagnosed with C. diff., others in the facility with a "stomach bug" were tested, but Resident #4 was the only one with a confirmed case of C. diff. - On his last visit the doctor instructed staff to extend isolation precautions for 7 more days and to obtain a stool sample. - The facility was continuing contact precautions pending the collection of a stool specimen. - Staff had not observed Resident #4's stool but she thought it was going from loose to more of a formed stool. - She was not sure if the physician was made aware of the Resident's stool status. - Adherence to precautions was expected.	D 276		

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D 276	Continued From page 8 Interview on 04/29/15 at 4:55 PM with the Resident Care Director (RCD) revealed: - She expected precaution signs were posted in rooms and all food was provided on disposable equipment. - It was important to protect the "outside public." - All staff were talked to regarding precautions, trained during their orientation and received periodic training every 6 to 12 months on infection control. - Staff performed hand hygiene by going to restrooms in the halls or sinks in the area to wash hands and they had carried hand sanitizer on their persons. - The doctor extended precautions for 7 more days. - She did not think staff had assessed her stool consistency but she thought it was going from more loose to more formed. Interview on 04/29/15 at 5:30 PM with Supervisor #2 revealed: - She was assigned to the medication cart for the hallway where Resident #4 resided. - She washed her hands in the women's bathroom in the hallway after delivering care. Interview attempt on 04/30/15 at 8:25 AM with Resident #4's attending physician revealed a message left with his office staff which was not returned at the time of exit. Phone interview on 04/30/15 at 8:45 AM with a family member of Resident #4 revealed: - They had visited on a Wednesday recently, for which they could not remember the exact date, and was not aware that Resident #4 was still sick and on "quarantine." - The weekend following the Wednesday visit, the	D 276		

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family member was sick with "bad diarrhea" and "rode it out," choosing not to see a doctor
- They stated there was no sign on the door to Resident #4's room and that if one was there they would have gone home.

Phone interview on 04/30/15 at 8:59 AM with another family member of Resident #4 revealed:
- The hospital informed the family member that Resident #4 had C. diff, the Resident had to stay in her room and staff was needing to collect a stool sample.
- The doctor was going to see Resident #4 on 05/01/15 and was "keeping a close eye on her."
- The family member was not "100% sure" if Resident #4 still had loose stools.
- A sign was posted on the Resident's bathroom door but not on the door to her room or on the wall outside her door.
- No "special precautions" were communicated by the staff.
- The family member noted staff were using regular dishes, cups and silverware.
- The family member noted staff were not washing their hands in the Resident's room and was not sure if they were doing it when they left the room.
- The family member noted not seeing hand soap or paper towels in the Resident's bathroom for staff use.
- The family member noted that the Resident would hit the call button on the pendant around her neck, staff would enter the room and have to push the button to shut it off, doing this with ungloved hands.

Interview on 04/30/15 at 11:00 AM with the Executive Director revealed:
- His expectation that staff and residents be protected by adherence to policies in place for

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D 276	Continued From page 10 infection control measures. - Contact precaution procedures were "very spelled out." - Staff had obtained a stool specimen that morning and were awaiting laboratory results to determine if Resident #4 could come off isolation precautions. - There was an all-staff meeting where isolation precaution policies were reviewed. Review of laboratory results with a facsimile date/time stamp of 04/30/15 at 11:10 AM revealed: - A stool specimen for Resident #4 verified by the laboratory on 04/29/15 at 9:47 PM as negative for C. diff. toxin A/B and positive for an antigen specific to C. diff . - A laboratory recommendation noted that if the antigen was positive and the toxin A/B was negative, confirmation of a negative toxin was indicated with another test. - Handwritten comments with the physician's initials included a line drawn to the recommendation and the additional comment "send this for C. diff." - Physician handwritten comments that if Resident #4 was having diarrhea then to resume metronidazole 500 mg TID for 10 days and to resume contact precautions. --- A Plan of Protection was obtained from the Executive Director on 04/30/15 at 11:15 AM which included the following: - The RCD was directed to review appropriate infection control practice with team members. - The RCD was directed to provide an in-service on appropriate handwashing technique to all staff - Care would be provided in accordance to the rules and regulations governing assisted living in	D 276		

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D 276	Continued From page 11 the state. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JUNE 6, 2015.	D 276		
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 observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to infection control. The findings are: Based on observation, record review and interviews, the facility failed to implement infection control measures ordered by the physician for 1 of 1 residents (Resident #4) with Clostridium difficile (C. diff.) [Refer to Tag 276, 10A NCAC 13F .0902 (c)(3)and (4)(Type B Violation).]	D912		