STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076005	A. BUILDING: _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF ASHEBORO	2925 ZOO PARKWAY ASHEBORO, NC 27204

(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 and complaint investigation on October 22 and October 23, 2015.	D 000		
D 361	10A NCAC 13F .1004(d) Medication Administration 10A NCAC 13F .1004 Medication Administration (d) Liquid medications, including powders or granules that require to be mixed with liquids for administration, and medications for injection shall be prepared immediately before administration to a resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared for administration in advance were kept enclosed in a sealed container that identified the name and strength of each medication prepared and the resident's name for 1 of 5 sampled residents (Residents #5). The findings are: Review of Resident #5's Resident Register revealed an admission date of 09/24/2009. Review of Resident #5's current FL2 dated 4/16/15 revealed: - Diagnoses included depression, osteoporosis, heart stent, thyroid, frequency/urgency, Alzheimer's Dementia. Review of Resident #5's October 2015 Medication Administration Record (MAR) revealed: -An entry for Morphine Sulfate 100mg/5ml - Take 0.25 ml (5mg) by mouth/under	D 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076005	A. BUILDING: _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF ASHEBORO	2925 ZOO PARKWAY ASHEBORO, NC 27204

(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 361	Continued From page 1	D 361		

tongue every 3 hours as needed for pain, dyspnea.
-The Morphine Sulfate was documented as administered by a Medication Aide one time on October on 10/01/15 at 9:48 pm.

Review of Resident #5's record revealed:
-Resident was a client of Hospice for the primary diagnosis of Alzheimer's Disease.
-A physician's order dated 8/13/15 prescribing Morphine sulfate 100mg/5ml - Take 0.25 ml (5mg) by mouth/under tongue every 3 hours as needed for pain, dyspnea.

Observation on 10/22/15 at 2:53 pm of the medication cart revealed:
-A red translucent box with no label which in a locked compartment of the locked medication cart.
-Inside the box there were seven 1ml syringes calibrated by even number of twos.
-Each syringe was filled with 0.26 ml of a clear, light blue substance.
-The syringes were not labeled.
-There was a box with a medication label that was labeled for Resident #5 and it was filled 8/31/15 which contained one 15 ml bottle of Morphine sulfate 100mg/5ml with instructions to give 0.25 ml (5mg) by mouth/under tongue every 3 hours as needed for pain, dyspnea.
-The bottle had approximately 13 mls of Morphine sulfate, a light blue substance left in the bottle.

Interview on 10/22/15 at 2:54 pm with a Medication Aide revealed:
-The syringes in the red translucent box belonged to Resident #5.
-The syringes were filled by Resident's #5's Hospice Nurse.
-The syringes were counted along with the bottle

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076005	A. BUILDING: _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF ASHEBORO	2925 ZOO PARKWAY ASHEBORO, NC 27204

(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 361	Continued From page 2	D 361		

every shift against the controlled substance log for the Morphine Sulfate.
-She was not aware the syringes were prepared at the incorrect dose.
-She had never administered the medication, but it had been administered once.

Interview on 10/22/15 at 3:00 pm with the Resident Care Director revealed:
-He knew the prefilled syringes were in the medication cart.
-The syringes were Resident #5's because he witnessed the Hospice Nurse filling the syringes with the Morphine sulfate.
-He was aware the box and the syringes should have been labeled.
-The Hospice Nurse prefilled the syringes, because Hospice did not want to incur the pharmacy's charge to prefill the syringes.
-He was not aware the dosage was incorrect.

Interview on 10/22/15 at 3:05 pm with a second Medication Aide revealed:
-She had administered one syringe to Resident #5 and was not aware it was the incorrect dose.
-She knew the syringes belonged to Resident #5, because staff counted them every shift.
-She signed out one dose of the medication on the MAR and on the controlled substance log on October on 10/01/15 at 9:48 pm.

Interview on 10/22/15 at 3:14 pm with a Hospice Nurse assigned to Resident #5 revealed:
-Hospice nurses routinely prefilled syringes at the facility to avoid medication errors.
-She knew to label each syringe for each resident with the name of the medication.
-She was sick when these syringes were filled and was not the nurse who prefilled them. She was unaware of who had filled them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076005	A. BUILDING: _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF ASHEBORO	2925 ZOO PARKWAY ASHEBORO, NC 27204

(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 361	Continued From page 3 -She was unaware that the syringes were not calibrated correctly for the ordered dose and the syringes were prefilled at an incorrect dose. Interview on 10/22/15 at 3:10 pm with the Administrator revealed: -She was aware that Hospice Nurses prefilled the syringes. -She provided the documentation where Hospice Nurses were expected to prefill the syringes for the facility staff when needed. -She did expect that the syringes were to be labeled. -She was not aware the syringes were not labeled. Interview on 10/23/15 at 9:04 am with the Regional Nurse revealed: -She was unaware the unlabeled syringes were stored in the medication cart. -It was her expectation the syringes be filled properly and the syringes be labeled by the facility's contract pharmacy or the Hospice pharmacy. -The facility was between Hospice Nurses because the regular Hospice Nurse took a different position and the nurse that was filling in must not have known to label the syringes.	D 361		