Accepted - 12/20/2021

CARILLON OAKS

Facility Name: Carillon Oaks Mobile
Facility ID: P4917
Exit Survey Date: 10/19/2021
Deficiency Number: A608

Deficiency:420-5-20-.06 (3) Care of Resident
No form of chemical restraint or seclusion shall be applied to residents of specialty care assisted living facility except in extreme emergency situations when the resident presents a danger of harm to himself or herself or to other residents.

Corrective Action:

RI#4 care plan has been updated to ensure staff knows our intervention for behaviors. Consulting company, IGH Health Services, came in 8-18-2021 to review care plans and train Director of Nursing and Unit Coordinator on updating care plans.

1. Care plans have been updated for each resident as needed and filed in resident charts.
2. Outside consulting service IGH will do audits monthly for three months then quarterly thereafter to ensure care plans are updated properly for six months.
3. All finding from IGH audits will be reviewed at QA meetings for one year.

Systemic changes implemented to assure the same deficiency will not reoccur:
Director of Nursing or Designee will review all updated care plans for proper interventions. Turenne Pharmacy will do quarterly quality assurance for one year to ensure medications are being used as directed. Executive Director and Director of Nursing met with the Medical Director and discussed survey results during QA. Facility will notify Medical Director when any PRN medication is used for extreme anxiety. Executive Director or Designee will hold monthly behavior meeting with Director of Nursing and Unit Coordinator to go over all behaviors. Any resident with new behaviors will have care plan reviewed and updated during behavior meeting. Behavior meeting findings will be discussed with Medical Director during QA meeting. IGH will perform audits monthly for three months then quarterly thereafter for six months to ensure care plans are updated properly.

Monitoring of proposed corrective action:
Executive Director /Designee will audit two care plans at random monthly to audit to ensure interventions are being added to care plans. Director of Nursing or Designee will review all updated care plans for proper interventions. Monthly audits will be documented on QA form and maintained in POC binder in Executive Directors office.
Monthly audits will be completed by Executive Director or designee starting 11/29/2021

Administrator: _____ Date: 11/29/2021

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Facility Name: Carillon Oaks Mobile
Facility ID: P4917
Exit Survey Date: 10/19/2021
Deficiency Number: A604

Deficiency:420-5-20-.06 (3) (j) Records and Reports
Facility must ensure care is provided in a timely manner.

Corrective Action:

Executive Director, Director of Nursing and Unit Care Coordinator on the importance of properly documenting care that residents receive.

1. DON and Unit Coordinator reviewed care plans on 10/20/2021 to ensure they are documented completely.
2. Outside consulting service IGH to trained DON and Unit Care Coordinator on properly updating care plans on 8-18-2021.

Systemic changes implemented to assure the same deficiency will not reoccur:
Executive Director, Director of Nursing and Unit Care Coordinator were trained on how to properly documenting care that residents receive. IGH to review care plans during monthly visits for three months and quarterly thereafter for six months to ensure facility is documenting care that residents receive. Any findings will be reviewed during QA meeting for one year.

Monitoring of proposed corrective action:
Executive Director /Designee will review at least two care plans a month to ensure they properly documented for six months. IGH will review care plans during compliance visits for three months and quarterly after for six months to ensure facility is documenting care that residents receive. Monthly and quarterly audits will be documented on QA form and maintained in POC binder in Executive Directors office.
Monthly audits will be completed by IGH starting in December.

Administrator: _____ Date: 11/29/2021

CARILLON OAKS

Facility Name: Carillon Oaks Mobile
Facility ID: P4917
Exit Survey Date: 10/19/2021
Deficiency Number: A611

Deficiency:420-5-20-.06 (4) (a) (b) Care of Resident
Facility must update the resident's care plan when there was a significant change in health status or behaviors.

Corrective Action:

Director of Nursing and Unit Care Coordinator were trained by Outside consulting service IGH on 8-18-21 on properly updating care plans.

1. All care plans were checked to ensure accuracy by DON/Designee on 10/20/2021.
2. All staff educated on observing and reporting change of conditions by DON on 11/19/2021.
3. Care plans have been updated for each resident as needed and filed in resident charts.

Systemic changes implemented to assure the same deficiency will not reoccur:
Director of Nursing will review all care plans once updated and ensure care plans are updated after significant change of condition. Any changes of condition will be discussed with Executive Director and Director of Nursing at least weekly in the morning meeting. IGH will perform audits monthly for three months then quarterly thereafter for six months to ensure care plans are being updated properly.

Monitoring of proposed corrective action:
Executive Director /Designee will audit two care plans at random monthly to ensure any change of condition is updated. Monthly and quarterly audits will be documented on QA form and maintained in POC binder in the Executive Directors office. Monthly audits will be completed by Executive Director or designee starting 11/29/2021. Monthly audits will be completed by outside consulting service IGH starting December.

Administrator: _____ Date: 11/29/2021

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Facility Name: Carillon Oaks Mobile
Facility ID: P4917
Exit Survey Date: 10/19/2021
Deficiency Number: A1204

Deficiency:420-5-20-.12 (6) Physical Environment
Facility must maintain proper functioning of porch gate and smoke doors to ensure the latching hardware functioned properly when the fire alarm is activated.

Corrective Action:

All affected doors were repaired at the time of survey on 10/19/2021

Systemic changes implemented to assure the same deficiency will not reoccur: Executive Director or Designee will check all affected doors every week for four weeks. After four weeks all doors will be checked monthly. All findings will be reviewed in QA meeting for six months.

Monitoring of proposed corrective action:
Executive Director /Designee will check doors for proper operation. Monthly and weekly audits will be documented on QA form and maintained in POC binder in Executive Directors office. Monthly and weekly audits will be completed by Executive Director or designee starting 11/29/2021.

Administrator: _____ Date: 11/29/2021

CARILLON OAKS

Facility Name: Carillon Oaks Mobile
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Exit Survey Date: 10/19/2021
Deficiency Number: A615

Deficiency:420-5-20-.06 (5) (h) Care of Resident
Facility must ensure the nurses documented at the time when medications are administered.

Corrective Action:
All Resident MARs were reviewed for missing documentation on 10/20/2021

1. All nursing staff trained on the importance of documenting in the MAR.
2. Turenne pharmacy came in on 11/17/2021 to educate Director of Nursing and Unit Care Coordinator on how to check and Identify med variance in the MAR.

Systemic changes implemented to assure the same deficiency will not reoccur:
Director of Nursing to review resident MARS weekly to ensure no missing documentation.
Pharmacy to perform QA at least quarterly to ensure proper compliance. Outside consulting service IGH Health Services to audit MAR for three months and quarterly after for six months to ensure compliance.
Monitoring of proposed corrective action:
Director of Nursing will audit MARS weekly to ensure no missing documentation.
Monthly and quarterly audits will be documented on QA form and maintained in POC binder in Executive Directors office. Monthly audits will be completed by IGH starting December.

Administrator: _____ Date: 11/29/2021

CARILLON OAKS

Facility Name: Carillon Oaks Mobile
Facility ID: P4917
Exit Survey Date: 10/19/2021
Deficiency Number: A508

Deficiency:420-5-20-.05 (3) (h) Records and Reports
Facility must ensure that a thorough investigation is completed for an injury of unknown origin.

Corrective Action:

Executive Director, Director of Nursing, Unit Care Coordinator were trained on how to complete a thorough investigation.

1. Executive Director, DON, Unit Care Coordinator, and state surveyor reviewed multiple incident reports to ensure they were completed properly.
2. Outside consulting service IGH to train Executive Director, DON, Unit Care Coordinator on properly completing a thorough investigation.
3. IGH Health Services LLC (IGH) to review incident reports during monthly visits for three months and quarterly after that for six months.

Systemic changes implemented to assure the same deficiency will not reoccur:
Executive Director, Director of Nursing, Unit Care Coordinator were trained on how to complete a thorough investigation. IGH to review incidents during compliance audits to ensure facility is completing a thorough investigation. Any findings will be reviewed during QA meeting for six months.
Monitoring of proposed corrective action:
Executive Director /Designee will review all incidents to ensure they are completed thoroughly. IGH will review incident investigations during compliance visits.
Monthly and quarterly audits will be documented on QA form and maintained in POC binder in Executive Directors office. Monthly audits will be completed by IGH starting December.

Administrator: _____ Date: 11/29/2021

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Facility Name: Carillon Oaks Mobile
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Exit Survey Date: 10/19/2021
Deficiency Number: A504

Deficiency:420-5-20-.05 (3) (d) Record and Reports
Facility must honor resident rights for the confidential treatment of resident records and prove a safe and decent environment for all residents.

Corrective Action:

The Narcotic count book and all resident documentation was removed at time of survey from the med cart when not in use.

1. All nursing staff educated on locking up Narcotic book and 24-hour report when not in use.

Systemic changes implemented to assure the same deficiency will not reoccur:
All nursing staff will be educated on locking up Narcotic book and 24-hour report when not in use. The Executive Director/Designee will do weekly visual inspections to ensure Narcotic book and 24-hour report is locked up when not in use for four weeks and then monthly for six months. IGH Health Services came to review charts and train Director of Nursing and Care Coordinator on properly documenting on resident care plans on 8-18-2021. Director of Nursing or designee will audit at least two care plans weekly for four weeks then monthly for six months. IGH will do audits monthly for three months then quarterly after to ensure care plans are updated properly. All findings from IGH compliance visits will be reviewed at QA meeting for one year.

Monitoring of proposed corrective action:
Executive Director /Designee will do weekly visual inspections audit for three months. Monthly audits and weekly audits will be documented on QA form and maintained in POC binder in Executive Directors office. Weekly and monthly audits of care plans will be completed by DON or designee starting 11/29/2021.

Administrator: _____ Date: 11/29/2021