STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 Franklin County Department of Social Services conducted an annual and follow-up survey and complaint investigation from September 14-21, 2015.	D 000		
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: TYPE B VIOLATION Based on interview and record , the facility failed to assure 1 of 6 sampled staff had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hired. (Staff A) The findings are: Review of Staff A's, Admimistrator-in-Charge, personnel record revealed: -She was hired as to work as the Business Office Manager on 2/23/15. -A Health Care Personnel Registry (HCPR) check was completed on 9/15/15. There was no substantiated findings listed on the HCPR. -There was a letter dated 8/24/15 offering her the Interim Executive Director/Administrator-in-Charge position and was signed by her on 8/24/15 accepting the	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 1 position. Interview with the Administrator-in-Charge on 9/17/15 at 12:30 p.m. revealed she was not aware there was no documentation of a HCPR check in her personnel file until she was informed by a member of the survey team on 9/15/15. Interview with the Administrator-in-Charge/Interim Administrator on 9/21/15 at 4:25pm revealed: -The previous Business Office Manager did all her personnel paperwork when she was hired. -Currently she is doing the job of the Business Office Manager and Interim Executive Director. -Moving forward, the Business Office Manager will be responsible for doing HCPR checks on new employees. -A new hire checklist was developed around the time she was hired. -A revised new hire checklist was implemented in June or July (2015) and is being used currently. Interview with the licensed Administrator on 9/16/15 12:30 p.m. revealed: -When the Administrator-in-Charge was hired to work at the facility, the prior Executive Director maintained staff records. -She was not aware there was no documentation of a HCPR check in the Administrator-in-Charge personnel file until she was informed by a member of the survey team on 9/15/15. The previous Business Office Manager was not available for interview. The facility submitted a Plan of Protection dated 9/21/15, which revealed the following: -Immediately (9/15/15), the facility completed a Health Care Personnel Registry (HCPR) check	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 2 on the Administrator-in-Charge. -All staff charts will be reviewed by the Administrator/Designee by 9/22/15 to make sure there is documentation of the HCPR checks in the staff's personnel records. -The Administrator/Designee will review staff personnel files monthly to make sure there is documentation of the HCPR checks in staff's personnel records. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 5, 2015	D 137		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, record review and interview, the facility failed to assure personal care was provided to 1 of 6 sampled residents who needed 2-person assistance and received a leg lacreation while staff provided personal care. (Resident #6). The findings are: Review of Resident #6's Resident Register	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 3	D 269		

revealed the resident was admitted to the Alzheimer's care facility on 2/21/2014.

Review of Resident #6's current FL-2 dated 4/09/15 revealed:
- Diagnoses included dementia, left femur fracture (acute, new), hypertension, and urinary tract infection.
- Activities requiring "Extensive Assist" were ambulation, transfers, toileting and bathing.

Review of Resident #6's Care Plan dated 5/14/15 revealed the resident required extensive assist with toileting, bathing, and transferring.

Review of Resident #6's Resident Care Plan dated 5/13/15, documented under ADL (acitvities of daily living), the resident needed a 2-person mechanical lift assist Functional Status, revealed:
- The resident needed a 2-person/mechanical lift with sling assist for bathing, toileting, and transferring.
- "1 Point Per Person Needed".

Review of the facility Incident Report for Resident #6 dated 4/05/15 revealed :
- On 4/05/15 at 3:00 pm the resident, seated in her wheelchair, had a fall to the floor while trying to pick up a paper she had been looking for.
- The resident was transported to a local hospital by EMS for sprain/strain (left leg).

Review of a staff Communication Log dated 4/05/15 for 3:00 pm revealed the "resident fell out of her wheelchair and had to be sent out to (a local hospital)."

Review of local medical center Emergency Department admission records dated 4/05/15 for Resident #6 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 4	D 269		

- The resident was seen by Emergency Medicine at 4:31 pm 4/05/15.
- The resident had an external rotation and swelling to the left thigh suspicious for femur fracture.
- The patient had a history of extensive and advanced Alzheimer's disease, but does report "I slid out of my wheelchair".
- The resident had surgery for a left femur fracture.
- The resident was discharged on 4/10/15 wearing a left leg brace.

Record review revealed no documentation of Resident #6 having any falls prior to 4/05/15.

Interview with a Medication Aide (MA) who worked on 1st and 2nd shifts revealed:
- Residents were closely monitored as this was an Alzheimer's care facility.
- A personal care aide (PCA) would be located in each section (living room, dining rooms, and 2 hallways) assisting residents and making rounds.
- Staff kept an eye on residens at all times, but if residents were in their rooms, they were physicially checked on every 15-20 minutes, 30 minutes, or 1 hour depending on their needs and care plan.
- All of the residents had different levels of dementia and were monitored according to care plan.
- The MA did not work the evening Resident #6 slid out of her wheelchair.

Record review revealed no Progress Notes for Resident #6 for April, 2015.

Interview on 9/16/15 at 11:17 am with Resident #6's Power of Attorney (POA) revealed:
- Resident #6 was totally disabled at the knees

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 5	D 269		

and ankles due to arthritis, could not bear weight, and was confined to a wheelchair.
- On 4/05/15 the POA was called by staff at the facility to report Resident #6 slid out of her wheelchair about 3:00 pm and fractured her left leg.
- On 4/05/15 Resident #6 reported to the POA (while in ER) she wanted something on the top of her dresser, tried reaching too far forward while seated in her wheelchair, slid out out the wheelchair and fell to the floor.
- The POA stated he had a good rapport with the staff and visited the resident regularly.
- Staff watched the resident closely, checking in on her every 15 minutes.

Review of Progress Notes for Resident #6 dated 7/09/15:
-"While (personal care aide) was providing incontinent care, resident was turned to her side, leg brace in place, she received a laceration to her upper right thigh.
- EMS notified; resident transported to ER; son notified.
- She returned with staples in place to be removed in 10-14 days."

Review of an Incident Report for Resident #6 revealed:
- On 7/09/15, at 10:40 pm, the resident received a skin tear to the right leg while in bed.
- The "Brief Description of the Incident" portion of the report was blank.

Review of local medical center Emergency Department admission records and treatment summaryfor 7/10/15 for Resident #6 revealed:
-The resident was seen by Emergency Medicine at 1:25 am on 7/10/15.
- Chief Complaint was leg laceration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 6 -The patient had a skin wound to the right thigh. -"The patient had a known left leg fracture at the distal femur which required a brace; the patient was non-ambulatory. - While she was being transferred the edge of brace contacted her right thigh and a skin wound was noted." - There was a crescent shaped 8 cm. laceration towards the middle aspect of the lower mid thigh; there is exposed subcutaneous fat. - The epidermis (skin) is very thin and fragile. - Wound repair was performed and the edges were brought together with a total of 12 surgical staples. - Staples were to be removed in 10-14 days. - A dressing was applied, wound care instructions were given (Physician's Directions order attached). - She will be transported back to the facility with the instructions. Second interview with a Medication Aide (MA) who worked on 1st and 2nd shifts revealed: - The MA worked on 1st shift on 7/10/15. - A 2nd shift personal care aide (PCA) was changing (Resident #6) on 7/09/15; the resident got a laceration on the right leg and was taken to the hospital. - The PCA was alone with the resident, but the resident needed a 2-person assist especially with the brace. - One person could hold the leg with the brace and the other give the personal care. - Staff had not received training on how to handle toileting with the brace on (Resident #6's) leg; I guess it was supposed to be a "common sense thing". - All staff should have known (Resident #6) was a 2-person assist for personal care.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 7 Confidential interview with a 2nd shift Personal Care Aide (PCA) revealed: - The PCA worked on the evening of the incident with Resident #6 (7/09/15) and started to work at the facility only 3 days earlier. - The PCA did not know Resident #6 had leg surgery, but knew she wore a leg brace and was told to keep it on at all times. - The PCA had not received training on how to do personal care for the resident with the brace on the left leg. - It was in Resident #6's care plan that she was a 2-person assist for anything except eating. - The PCA saw the MA come out of Resident #6's room asking "what happened to (Resident #6's) leg?" - Another PCA, standing by the nurse's station, said she had just come out of the resident's room and Resident #6's brace had scraped her leg. - The MA said "it was a gash and might need stitches". - The MA said she was going to call the EMS and send the resident to the hospital. -The PCA who was in Resident #6's room was by herself to do personal care and the resident needed a 2-person assist. - It was a facility policy that PCAs were supposed to read resident's care plans before doing resident care. Confidentiak interview with a second 2nd Shift PCA revealed: - The PCA also worked on the evening of the incident with Resident #6 (7/09/15) and had started to work at the facility only 3 days earlier. - The PCA was told Resident #6 was a 2-person assist by the MA and had also read it in resident's care plan and on her assignment sheet. -The resident had a leg brace, her skin was very sensitive and needed to be handled very	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 8	D 269		

carefully.
- The PCA had not had any training on how to handle the brace except for "carefully" by the MA.
- The PCA was making rounds on the "bottom" of the hall when another PCA came out of Resident #6's room and notified the MA that the resident had a skin tear.
- The MA was at the medication cart and went to check Resident #6's leg.
- The MA came out of the room saying "Lord, that is more than a skin tear!"
- The PCA that was in Resident #6's room to do personal care said that she was changing the resident and the resident's leg got a tear from the brace; the brace had a round metal piece that cut into the resident's inner thigh above the knee and was bleeding.

Confidential interview with a third 2nd Shift PCA revealed:
- The PCA was new, and 7/09/15 was only about the 2nd or 3rd evening she had been working at the facility.
- The PCA's hire date was 6/30/2015.
- She was supposed to be in orientation and "shadowing" another PCA, but was given an assignment on her own the night of (Resident #6's) incident.
- Resident #6 was part of her assignment.
-The PCA went alone to Resident #6's room to check on the resident, smelled the odor of bowel movement, checked the resident's diaper, left the room to get toileting supplies, and returned alone to clean up the resident.
- The resident had a brace on her left leg.
- The PCA turned the resident on her right side, having the left leg with brace lying on top of the bare right leg.
- The PCA turned the resident back over and saw a skin tear on the right leg.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 9	D 269		

- The tear was a half-moon shape in the resident's right leg and was bleeding.
- The PCA left the room to notify the medication aide (MA) of the incident.
- The MA informed the PCA that Resident #6 was a 2-person assist for care and she would need to call EMS and the family.
- The PCA did not remember who had handed her the assignment sheet.
-The PCA went into the resident's room not knowing about the care for the resident or the brace.
-No staff had mentioned having training about the brace.
- The PCA was trying to give the resident the best care she could.
- It was the facility's responsibility to give her instructions on the resident's personal care needs.
- "It would have most definitely helped to know the resident was a 2-person assist and had the brace."

Repeated attempts to contact the 2nd Shift medication aide who worked on 7/09/15 for interview were unsuccessful.

Interview on 9/21/15 at 3:30 pm with Resident #6's Orthopaedic group's Office Manager revealed the resident had a neoprene knee immobilizer brace placed on her left leg after surgery.

Interview on 9/21//15 at 3:45 pm with an Orthopaedic Surgical Technician specialist for durable medical equipment (DME) revealed:
- There was a hinge on both sides of the neoprene brace having a rounded hard plastic dial-shaped piece used for locking and unlocking and changing the angle of the brace to enable the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 10 knee to bend. - The hard plastic was about 1-1/2" to 2" in circumfrence and about 3/8" thick. - The skin on the braced leg was protected by padding on the back of the dial. - On elderly, friable (thin, easily broken, semi-transparent) skin, if the dial part rubbed against the skin of the other leg, it would cause chaffing, skin breakdown, or laceration. - Padding, such as a large, thick sock, would be needed to protect the skin from damage. - Often a pillow would be used, to protect the bottom leg's skin, but was usually too big when having to do personal care. Review of staff Communication Logs revealed: - Documentation entries for the months of April through June, 2015 contained no information about the use Resident #6's leg brace. - Log dated 7/09/15 revealed Resident #6 had a laceration to the right thigh at 10:30 pm; the brace tore her skin while rolling over to be changed, EMS was called and the resident was taken to a local medical center. - For description of follow-up or corrective steps: always have 2 people when doing care on her and transferring (Resident #6). - Log entry signed by the 2nd shift medication aide (MA). - Log dated 7/10/15 at 11:15 am revealed (Resident #6) was a 2-person assist at all times, under no circumstances should one caregiver provide care for resident unless assisting with meals; please be instructed that leg brace should be taken off when providing care, dressing, toileting, skin is very, very, brittle and we must be gentle when rolling or providing care. -Log entry signed by the Resident Care Coordinator (RCD).	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 11	D 269		

Review of the Licensed Health Professional Support (LHPS) quarterly report for 6/30/15 for Resident #6 revealed:
- Primary Diagnoses: Left femur fracture, Dementia, Hypertention
- Personal Care tasks currently present: (please check all that apply) were for "Feeding techniques for residents with swallowing problems" and ttransferring semi-(or) non-ambulatory residents.
- Assessment documentation included "chart reveals resident requires extensive assistance with transfers".
- The "Applying and removing ace bandages, TED hose and binders" box was not checked as a current task for Resident #6.
- There was no documentation that the resident wore a brace on her left leg.

Interview on 9/18/15 at 9:23 am with the LHPS nurse revealed:
- The LHPS nurse did not give training to the facility staff for the care and use of Resident #6's brace.
- The LHPS nurse had not received an order from the Resident Care Director (RCD) to train staff for the care and use of a brace for the resident.

Interview on 9/18/15 with Resident #6's primary care physician's (PCP) nurse practitioner reveled:
- A follow-up visit was made on 7/10/15 as per the hospital's discharge instructions.
- The resident was also seen again on 7/15/15 to check on the dressing.
- After consultation with the resident's PCP, orders were given for wound care and staff instructions for care of the leg brace.

Review of Visit Summary dated 7/10/15 by the Nurse Practitioner (NP) for Resident #6's primary care provider (PCP) revealed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 12 - "Right leg laceration closed with staples, continue to be CAREFUL with changing positions with patient's leg." - "Med Techs (medication aides) are the only staff to take on and off leg brace." -"Watch for signs and symptoms of infection including increased pain, swelling, redness, fever." Review of NP's order for Resident #6 dated 7/10/15 revealed: "Med Tech (medication aide) only to remove brace." Review of Visit Summary dated 7/13/15 by a second Nurse Practitioner (NP) for Resident #6 revealed: - Laceration on right thigh. -Home Health nursing will be ordered for wound care to start this week. - Will follow-up next week to determine whether staples are ready to be removed. - Pain in left leg, controlled with Vicodin. - Care of brace on left leg; orders drafted specifying when left leg brace should be removed (for cleaning/incontinence care). -Order for Physical Therapy (PT) to instruct the staff on caring for the patient with her brace; have discussed this directly with the medication aide and PT. Review of second NP's order for Resident #6 dated 7/13/15 revealed: - Brace may come off only when being bathed or cleaned; should be on at all other times. - Brace should be in unlocked (knee free) position at all times. - Physical Therapy has been ordered to give instruction. - 2-person transfers and bathing at all times.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 13 Review of Training/In-Service Documentation form dated 7/13/15 revealed: - Subject: Resident #6's leg brace. - Description: new orders for leg brace effective immediately. - Attendees: 14 staff signatures - Trainer: the facility Resident Care Coordinator (RCC) - Attached was the following notice by the Resident Care Director (RCD): To ensure safety and provide optimal care for our resident MA's only allowed to place and remove her leg brace. ABSOLUTELY NO EXCEPTIONS!!!; Orders only to remove for bathing and peri-care!; Orders for brace at knee to stay in UNLOCKED poition!; Orders for 2 person assist with ALL CARE to include any transfers/moving/positioning! Interview on 9/16/15 at 11:23 am with Resident #6's Power of Attorney (POA) revealed: - Resident #6 was totally disabled at the knees and ankles due to arthritis, could not bear weight, and was confined to a wheelchair. - On 4/05/15 the POA was called by staff at the facility to report Resident #6 slid out of her wheelchair about 3:00 pm and fractured her left leg. - On 4/05/15 Resident #6 reported to the POA (while in ER) she wanted something on the top of her dresser, tried reaching too far forward while seated in her wheelchair, slid out out the wheelchair, fell to the floor, and fractured her left femur. - The POA stated he had a good rapport with the staff and visited the resident regularly. - Staff watched the resident closely, checking in on her every 15 minutes. - The resident was discharged from the hospital with a brace on her leg. - The brace had steel rods covered in a neoprene	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 14	D 269		

fabric and had a steel hinge at the knee.
- The hinge was 1-1/2" - 2" in diameter encased in neoprene and padding; the ends of the metal rods curved and there were no sharp edges anywhere, no metal part would have come in contact with her skin.
- Resident #6 had a history of thin, fragile skin and had some skin tears in the past; she was frail, the resident was 96 years old.
- (The resident) needed a mechanical lift and sling and required 2-person assist for transfers; POA was paying extra for the 2-person assist.
- When the POA was called the night of the laceration incident (7/09/15), he was informed that 2 people went in to help Resident #6, 1 person to hold the leg with the brace, and another to do the personal care.
- In the course of getting the resident ready, a resident alarm went off and the staff holding the leg left the room to answer the alarm, leaving one person to take care of the resident.
- The caller informed the POA the resident had a 6 1/2 "gash in her leg.
- The caller also said the staff assisting the resident was new and did not know how to turn the resident; the more senior person had left the room.
- The POA was told by the facility director that only 1 person was assisting the resident with care at the time of the incident on 7/09/15.
- The day after the incident, the POA had not received a call from the facility and wanted to speak to someone.
- After getting no response to leaving a message, the POA called the facility's corporate office.
- The POA stated "why had no one called him about the incident?
- "The incident was negligent (care) to me."
- About 2 hours later the director called back and stated staff had no instructions from the hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 15	D 269		

or Resident #6's physician on how to handle the brace.
- The POA stated "(the facility) did nothing to obtain information on how to handle the brace; the (staff) had no way of knowing how to manage the brace."
- The POA was "appalled at the facility for showing no responsibility to get information."
- The POA stated "the personal care standard was not consistant, the person giving care did not know what they were doing or they did not have enough people to do it."
- The POA stated not knowing why the resident was not being assisted by 2 people and that "(the facility) dropped the ball".
- After the incident on 7/09/15, Resident #6 "went steadily downhill physically".
- The POA met with the resident's primary care doctor (PCP) on 7/17/15 and was told the resident needed to be placed with Hospice and had 6 months or less to live.

Interview on 9/21/15 a 4:45 pm with the Resident Care Coordinator (RCC) revealed:
- The RCC stated she was not working the evening of 7/09/15 when Resident #6 received a skin laceration, but was called by the medication aide (MA).
- A personal care aide (PCA) was changing the resident; when the PCA rolled the resident over, the PCA noticed the resident's right leg was bleeding more than a regular skin tear.
- Resident #6 was sent to the hospital.
- The RCC did not remember if the PCA was by herself with the resident.
- The PCA should have known the resident was a 2-person assist and the RCC did not know what happend about that.
- The RCC was not sure if the PCA had training to work with the brace.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 16 - The RCC stated she did the scheduling and managed staffing; she did not do training. Interview on 9/21/15 at 5:20 pm with the Resident Care Director (RCD) revealed: - The RCD was employed at the facility in June, 2015. - After having the leg fracture in April, 2015, Resident #6 came back to the facility wearing a brace on the left leg. On 7/09/15 a PCA went to Resident #6's room to give personal care. - When the resident was turned on her (right) side, a hard metal piece from the brace (on the left leg) rubbed the area above her right knee and lacerated the skin. - The laceration was bleeding, the MA called 911, and the resident was transported to the hospital. - The PCA with the resident had been alone and had not had any training on the brace. - The RCD did not know why there was not 2 people for the care, the staff should have been aware of that. - Part of the RCD's and the RCC's jobs were to help with staff training. - The RCD was not aware of any training given to staff on how to manage the brace for transferring the resident or for personal care. -Physical therapy or the LHPS nurse were not resquested to give training for use of the brace. - After Resident #6 received the skin laceration on 7/09/15, the RCD tried to find out information about using the brace, making some calls and doing internet searches, but did not find out much. - The RCD did not know if the brace was for short term or long term use or if it could come off for personal care; the resident had it on all of the time. - Resident #6's primary care physician's nurse	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 17 practitioner made a facility visit and spoke with an orthopaedic physician and was given directions for the brace on 7/15/15. Interview on 9/21/15 at 6:35 pm with the Administrator-In-Charge (AIC) revealed: - The AIC was aware of Resident #6's skin laceration on 7/09/15, but was not aware of any staff training that had been done for the brace. - The RCD (nurse) would have been responsible for training the staff in the use of the brace. - Resident #6 should have had a 2-person assist for personal care, not one. Interview on 9/21/15 at 7:10 pm with the Vice President of Operations revealed: - She knew of the wound Resident #6 received from the brace (7/09/15), but was unaware of any instructions obtained for brace care. - Systems were in place for resident care delivery. - Staff had not been trained on manipulating the brace and training needed to be done. - More clinical support was needed for resident care. _____ The Administrator-In-Charge provided a "Plan of Protection" for residents effective 9/21/15: The Nurse, or designee, will create a "2-person assist" list for all staff (to) review by 9/22/15 and will ensure care staff are knowledgeable. The Nurse, or designee, will update care staff at shift change on resident changes of condition.The Nurse, or designee, will provide training to all care staff on care plan changes. Nurse, or designee, will keep a log of daily monitoring of changes and Nurse, or designee, will provide new care plan changes to staff through the Communication Log and shift changes.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 269	Continued From page 18 CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 21, 2015.	D 269		
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 record review and interview, the facility failed to assure the implementation of discharge orders from a hospital physician for 1 of 6 sampled residents who did not receive wound care as ordered for a leg laceration requiring staples (Resident #6). The findings are: Review of Resident #6's Resident Register revealed the resident was admitted to the Alzheimer's care facility on 2/21/2014. Review of Resident #6's current FL-2 dated 4/09/15 revealed: - Diagnoses included dementia, left femur fracture, hypertension, and urinary tract infection. - Activities requiring "Extensive Assist" were	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 19 ambulation, transfers, toileting and bathing. Review of Resident #6's Care Plan dated 5/14/15 revealed the resident required extensive assist with toileting, bathing, and transferring. Review of Resident #6's Resident Care Plan dated 5/13/15, activities of daily living, revealed: - The resident needed a 2-person assist for bathing, toileting, and transferring. - "1 Point Per Person Needed (1-person or 2-person assistance designation)". Review of Progress Notes for Resident #6 dated 7/09/15: -"While (personal care aide) was providing incontinent care, resident was turned to her (right)side, leg brace in place, she received a laceration to her upper right thigh. - EMS notified; resident transported to ER; son notified. - She returned with staples in place to be removed in 10-14 days." Review of an Incident Report for Resident #6 revealed: - On 7/09/15, at 10:40 pm, the resident received a skin tear to the right leg while in bed. - The "Brief Description of the Incident" portion of the report was blank. Review of local medical center Emergency Department admission records for 7/10/15 for Resident #6 revealed: -The resident was seen by Emergency Medicine at 1:25 am on 7/10/15. - Chief Complaint was leg laceration. -The patient had a skin wound to the right thigh. -"The patient had a known left leg fracture at the distal femur which required a brace; the patient	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 20	D 276		

was non-ambulatory.
- While she was being transferred the edge of brace contacted her right thigh and a skin wound was noted."
- There was a crescent shaped 8 cm. laceration to the medial (towards the middle) aspect of the distal (lower) mid thigh; there is exposed subcutaneous fat.
- The epidermis (skin) is very thin and fragile.
- Wound repair was performed and the edges were brought together with a total of 12 surgical staples."
- Staples were to be removed in 10-14 days.
- A dressing was applied, wound care instructions were given (Physician's Order attached).
- She will be transported back to the facility with the instructions.

Review of the hospital Physician's Order dated 7/10/15 for Resident #6 revealed:
- 1. Wound care right thigh. Gentle cleanse every day Hibiclens/saline, pat dry. ABD pad/dry gauze, no ointment.
- 2. Staple removal 10-14 days.
- 3. RTC (return to clinic) or ED (emergency department) for concerns regarding infection.

Record review of Progress Notes for July 10-15, 2015 for Resident #6 revealed no documentation of facility nurse or medication aide processing hospital discharge orders (dated 7/10/15) or instructions for personal care staff to do wound care for the resident's skin laceration.

Record review of staff Communication Log entries for July 10-15, 2015 for Resident #6 revealed no documentation of wound care being given for the skin laceration.

Record review of the medication administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 21 records for July 10-15, 2015 for Resident #6 revealed no documentation of wound care being given for the skin laceration. Interview on 9/18/15 at 10:33 am with Resident #6's primary care physician's (PCP) office assistant revealed: - On 7/10/15 (nurse practitioner), covering for the PCP, visited the resident to do a follow-up visit for the laceration wound as per hospital discharge instructions. - On 7/15/15 the Home Health physical therapist (PT) for Resident #6 called to inform the physician that the resident's wound had not been cleaned since the resident was discharged from the hospital on 7/10/15. - When the PT asked for supplies to clean the wound, there were none available. - The wound care order was for Resident #6's wound was to be cleaned daily by the facility. - The PT was very upset with the facility for not giving the resident proper care. - The PT contacted Resident #6's PCP's office and discussed the lack of wound care with the nurse practitioner. - The nurse practitioner gave a verbal order for Home Health to provide wound care for the resident and Home Health was to start that day. Review of Home Health Agency Communication form dated 7/15/15 revealed: - PT received orders for Resident #6 for evaluation of skin wound that occurred due to new staff turning patient for peri-anal care and causing a (wound). - (Resident #6) wound has a gauze wrap with abd pad covering wound with an order for daily wound care. - "Dressing appears to be the one that was placed in the hospital".	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 22 - Called primary care physician (PCP) and requested a skilled nursing evaluation for wound care and received a verbal order from the Nurse Practitioner (NP). Interview on 9/21/15 with a 1st shift Medication Aide (MA) revealed: - After Resident #6 returned from the hospital for treatment of the leg laceration, staff thought Home Health was doing the laceration wound care as facility staff had not been given instructions to do it. - The MA was not aware of a discharge order for wound care, but became aware of the order from the RCD about 1 week after the resident returned to the facility. - The PT came in and looked at the dressing and noticed it had not been changed. - An order was obtained to have a Home Health Nurse change the dressing. - Hospitals would usually fax discharge instructions to the facility and the MAs or the RCD nurse would get it. -The nurse would read the order and then give instructions (to staff). - The original order had been overlooked. - The MA did not know how the order "fell through the cracks". - Attempted telephone interviews with the 2nd Shift Medication Aide were unsuccessful. Interview on 9/21/15 at 3:32 pm with Resident #6's Primary Care Physician's Nurse Practioner (NP) revealed: - The resident's laceration wound had no complications, but it could have had an infection or other complications; no one looked at it or changed the dressing for a week. - The staples could have come out (wound	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 23	D 276		

opening) and the wound could have been draining.
-The skin could have become macerated (having an excessive amount of moisture; can harbor fungus and bacteria, increasing the likeliness of infection and breakdown of the skin).
- The wound should have been cleaned as per the hospital discharge order.

Interview on 9/21/15 at 4:55 pm with the Resident Care Coordinator (RCC) revealed:
- Home Health was supposed to handle the dressing (for Resident #6), they were already here for another reason and should have picked up that one as well.
- The RCC did not read the hospital discharge notes; the nurse (RCD) handled clinical issues.

Interview on 9/21/15 at 5:30 pm with the Resident Care Director revealed:
- Hospital discharge instructions for facility residents were usually faxed to the facility at discharge.
- On 7/15/15 the Physical Therapist and the Nurse Practitioner for Resident #6 told the RCD the hospital laceration dressing had not been changed since the resident left the hospital on 7/10/15.
- The hospital discharge instructions for Resident #6 included an order for wound care to be done by facility staff daily.
- Home Health was given an order for wound care for Resident #6 the same day.
-The RCD remembered seeing the wound order attached to the discharge instructions for Resident #6, but did not remember if she read it.
- The RCD thought an order was sent to Home Health for hte wound care, but did not know if it had been.
-The RCD was responsible for reading the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 24 discharge orders and giving instructions to the staff. - No instructions had been given to the staff. Interview on 9/21/15 at 6:35 pm with the Administrator-In-Charge revealed: - The Medication Aides (MA) and the RCD were responsible for checking hospital discharge information and clarifying orders. Wound changes would have been documented in the Progress Notes and medication administration records (MAR). - The facility system for resident care was that the Nurse (RCD) and the MA clarified orders and made changes/instructions to a resident's care plan as needed and the information was documented on each PCA's shift care assignment. - The Administrator had not read the specific wound care order for Resident #6, but thought one had been attached to the last page of the hospital discharge instructions. Interview on 9/21/15 at 7:10 pm with the Vice President of Operations revealed: - There was a system in place for the following-up on Resident #6's (discharge) orders. -The system did not work. - Changes needed to be made so that staff would understand care and processes. _____ The Administrator-In-Charge provided a "Plan of Protection" for residents effective 9/21/15: The Nurse will review all discharge/physician orders upon residents' reurn to community (facility) as needed. The nurse, or designee, will communicate with care staff new orders through shift change meetings daily. The nurse, or designee, will follow new order tracking protocol	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 25 daily, while on site, to ensure new orders are processed appropriately. The nurse, or designee, will monitor documentation of care plan additions by care staff daily, while on site. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 5, 2015.	D 276		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have a matching therapeutic diet menu for 7 of 7 residents (#17, #9, #7, 13, #11, #12, #10) with diet orders for the controlled carbohydrate (CCHO) diet. The findings are: 1. Review of Resident #17's current FL-2 dated 4/7/15 revealed: -The resident's diagnoses included Type II Diabetes Mellitus, peripheral neuropathy, chronic renal failure, high blood pressure, diabetic retinopathy and short term memory. -There was an order for a No Concentrated Sweets diet, "Renal predialysis diet. Give a sandwich with meals and at bedtime." -The resident was admitted to the facility on 3/23/15.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 296	Continued From page 26 Review of Resident #17's record revealed: -There was had a subsequent order dated 4/24/15 for a "Renal and diabetic diet." -There was a current order for a No Added Salt, CCHO diet on the Care Plan signed by the physician dated 6/22/15. 2. Review of Resident #9's current FL-2 dated 3/12/15 revealed: -The resident's diagnoses included dementia, high blood pressure, coronary artery disease and Diabetes Mellitus. -There was an order for a Low Concentrated Sweets diet. Review of Resident #9's record revealed a subsequent order dated 3/13/15 for a CCHO diet. The Resident Register revealed Resident #9 was admitted to the facility on 12/21/13. 3. Review of Resident #7's current FL-2 dated 2/13/15 revealed: -The resident's diagnoses included dementia with psychotic behavior, insulin dependent diabetes and high blood pressure. -There was an order for a CCHO diet. The Resident Register revealed Resident #7 was admitted to the facility on 2/17/14. 4. Review of Resident #13's current FL-2 dated 12/29/14 included: -The resident had diagnoses of dementia and atrial fibrillation. -There was an order for a diabetic diet. Review of Resident #13's Care Plan signed by the resident's primary care physician on 5/8/15	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 296	Continued From page 27 revealed an order for a CCHO diet. The Resident Register revealed Resident #13 was admitted to the facility on 12/30/14. 5. Review of Resident #11's current FL-2 dated 5/8/15 revealed: -The resident's diagnoses included dementia with behavioral disturbance, high blood pressure and Type II Diabetes Mellitus. -There was an order for a CCHO diet. Review of Resident #11's record revealed there was a subsequent diet order dated 7/24/15 for a CCHO, NAS diet. The face sheet revealed the resident moved into the facility on 3/19/14. 6. Review of Resident #12's current FL-2 dated 12/19/14 revealed: -The resident's diagnoses included Alzheimer's dementia and insomnia. -The resident had an order for a Regular Vegetarian Diet. Review of Resident #12's record revealed a subsequent order dated 7/17/15 included a Regular diet. The Resident Register Revealed the resident was admitted to the facility on 1/26/14. 7. Review of Resident #10's current FL-2 dated 8/21/15 revealed: -The resident's diagnoses included Alzheimer's dementia and non insulin dependent diabetes mellitus. -There was an order for a Regular Diabetic diet. Review of Resident #10's record revealed:	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 296	Continued From page 28 -There was a subsequent order for a CCHO diet. -The progress notes revealed the resident was admitted to the facility on 6/20/15. Interview with the Dietary Supervisor on 9/14/15 at 1:31 p.m. revealed: -Breakfast was served between 7 a.m. and 8 a.m., lunch was served at 12:00 p.m. and dinner was served at 5:00 p.m. -The facility offered the CCHO diet for the diabetic residents. -The residents received sugar free desserts for the CCHO diet. -She would look for the spreadsheet menu dated 9/14/15, which included the LCS menu. Interview with the Dietary Supervisor on 9/15/15 at 11:54 a.m. revealed: -The facility followed the Low Concentrated Sweets (LCS) menu for the CCHO diets. -For lunch on 9/15/15 the residents would receive diabetic jello for dessert. Review of the company's diet form (no date) revealed the CCHO diet was the only diabetic diet available for the diabetics. Telephone interview with the company's dietitian on 9/15/15 at 12:20 p.m. revealed: -The company does not use and had never used the CCHO diet menu. -The only diabetic diet the company uses is the LCS menu. Interview with the Dietary Supervisor on 9/15/15 at 12:31 p.m. revealed: -She thought the LCS diet menu was the same as the CCHO menu. -She had been using the LCS diet menu for the CCHO menu since the facility had been opened	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 296	Continued From page 29 (2 years.) -She had just informed the dietitian the company's diet form had listed the CCHO diet. -The dietitian said she would update the diet order form to list the LCS diet as the only diabetic diet available. Review of the Cycle 1 2015 LCS Diet Lunch Menu for 9/15/15 revealed the residents were to be served 3 ounces (oz) chef ' s choice, ½ cup starch of choice, ½ cup vegetable of the day, 1 bread of choice, ½ dessert of the day and 1 diet beverage of choice. Review of the Cycle 1 2015 Renal Diet Lunch Menu for 9/15/15 revealed the residents were to be served 3 ounces (oz) chef's choice, ½ cup starch of choice, ½ cup vegetable of the day, 1 bread of choice, 1 serving of dessert of the day and 1 beverage of choice. Review of the diet list, which was posted on a bulletin board on a wall in the kitchen, revealed -Resident #9 was on a CCHO diet. -Resident #7 was on a CCHO diet. -Resident #13 was on a CCHO diet. -Resident #12 was on a CCHO diet. -Resident #10 was on a CCHO diet. -Resident #17 was on a CCHO/NAS diet. -Resident #11 was on a CCHO/No Added Salts diet. The facility clarified the diet orders for six residents who shared the same primary care physician. The orders dated 9/17/15 revealed: -Resident #9 was on a Low Concentrated Sweets (LCS) diet. -Resident #7 was on a LCS diet. -Resident #13 was on a LCS diet. -Resident #11 was on a LCS diet.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 296	Continued From page 30 -Resident #12 was on a LCS diet. -Resident #10 was on a LCS diet. Telephone interview with Residents #17, #9, #7, #13, #11, #12 and #10's primary care physician on 9/21/15 at 1:45 p.m. revealed: -The office did not keep a copy of the resident's diet orders. -If the residents had orders for a CCHO diet, she was not aware the facility did not have a menu for the diet. -Whatever diet the facility had on file was the diet the resident should be receiving. Observation of the lunch meal on 9/15/15 from 12:30 p.m. to 1:03 p.m. for 4 of 7 residents on the LCS diet revealed the following: -Resident #17 was served 1 slice of pepperoni pizza, 1 breadstick, ½ cup broccoli, 1 cup of cranberry juice and 1 cup of water. At 12:40 p.m. the resident had eaten the slice of pizza and breadstick and had requested another slice of pizza and a breadstick. The resident had eaten all of the meal and at 1:00 p.m. -Resident #11 was served 3 ounces (oz) chips, 1 ham and cheese sandwich, 1 cup of water and 1 cup of clear soda per resident ' s request. At 1:03 p.m. the resident had eaten all of the sandwich and chips, drank ½ of the clear soda and ½ of the water. -Resident #9 was served 1 slice of pepperoni pizza, 1 breadstick, ½ cup broccoli, 1 cup of cranberry juice and 1 cup of water. At 12:55 p.m., the resident had eaten all of the pizza and breadstick, had eaten half of the broccoli and drank all of the water and cranberry juice. -Resident #13 was served 1 slice of pepperoni pizza, 1 breadstick, ½ cup broccoli, 1 cup of cranberry juice and 1 cup of water. At 12:45 p.m., the resident had eaten all of the meal and	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 296	Continued From page 31 drank all of the beverages. Review of the Cycle 1 2015 LCS Diet Dinner Menu for 9/15/15 revealed the residents menu included 2 chicken strips with 1 oz dipping sauce, ½ cup macaroni and cheese, ½ cup green beans, 1 dinner roll, fresh fruit, 1 cup milk and 1 cup diet beverage of choice. Observation of the dinner meal on 9/15/15 from 4:40 p.m. to 5:00 p.m. for 3 of 7 residents on the LCS diet revealed the following: -Resident #12 was served 2 chicken tenders, ½ cup green beans, ½ cup macaroni and cheese, 1 roll, 1 cup water and 1 cup tea. At 5:00 p.m. the resident had eaten both chicken strips, the string beans, ½ of the roll, ½ of the macaroni and cheese and had drank both of the beverages. -Resident #10 was served 2 chicken tenders, ½ cup green beans, ½ cup macaroni and cheese, ½ cup mixed fruit, 1 roll, 1 cup water and 1 cup cranberry juice. At 5:09 p.m. the resident had eaten 1 and ¾ chicken strips, ½ macaroni and cheese, all of the string beans and mixed fruit, ¼ roll, drank all of the cranberry juice and ¾ water. -Resident #7 was served 2 chicken tenders, ½ cup green beans, ½ cup macaroni and cheese, 1 roll, 1 cup water and 1 cup cranberry juice. At 4:56 p.m., the resident had eaten all of the chicken tenders, macaroni and cheese, roll, juice and water. The resident did not eat the green beans. Interview with the Resident Care Director on 9/16/15 at 9:45 a.m. revealed: -The facility only offered the CCHO diet for the diabetics. -The CCHO diet orders had been used at the facility at least since she had been working at the facility (2 months.)	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 296	Continued From page 32 -She was not aware the facility did not have a menu for the CCHO diet orders. -The Administrator-in-Charge was responsible for dietary. Interview with the Administrator-in-Charge on 9/17/15 at 9:00 a.m. revealed: -She supervised dietary. -The CCHO diet was the only diabetic diet offered at the facility. -If a resident had an order for a CCHO diet, her expectation was for the resident to receive the diet as ordered. -She was not aware there was no menu available for the CCHO diet. Based on observation, interview and record review, the residents were not interviewable	D 296		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to serve milk to residents (census 43) in the special care unit twice daily.	D 299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 299	Continued From page 33 The findings are: Interview with the Dietary Supervisor on 9/14/15 at 1:31 p.m. revealed breakfast was served between 7 a.m. and 8 a.m., lunch was served at 12:00 p.m. and dinner was served at 5:00 p.m. Observation on 9/14/15 at 5:00 p.m. during the dinner meal revealed: -Thirty five residents were in the dining room. -Milk was not served to the residents. Review of the Regular Diet Menu for 9/15/15 revealed 1 cup of milk should be served at breakfast and ½ cup of milk should be served at dinner. Review of the Regular Diet Menus for 9/16/15 and 9/17/15 revealed 1 cup of milk should be served at breakfast and ½ cup should be served at lunch and dinner. Observation of the breakfast meal on 9/15/15 at 8:20 a.m. revealed all of the residents' beverages included 1 cup of milk. Observation of the lunch meal on 9/15/15 at 12:30 p.m. revealed milk was not offered and the residents did not receive milk during the meal. Observation of the dinner meal on 9/15/15 at 4:35 p.m. revealed: -Thirty one residents were in the dining room. -All of the residents received water and tea/juice. -None of the residents were served milk. Interview with a Personal Care Aide (PCA) on 9/15/15 at 4:44 p.m. revealed: -The residents are usually served water and	D 299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 299	Continued From page 34 tea/juices with the dinner meal. -Milk was not served to the residents during dinner unless the resident requested milk. Interview with a second and third PCA on 9/15/15 at 4:44 p.m. revealed: -They had just started working at the facility for three months. -Milk was only served at breakfast. -Dietary tells them the beverages to serve to the residents during the meals. -They had never served milk to the residents during lunch or dinner since they had been working at the facility. Interview with the Dietary Manager on 9/15/15 at 4:55 p.m. revealed: -The PCAs pass out the beverages to the residents. -Milk is usually served at breakfast. -She followed the menus for preparing beverages for the residents. -Two years ago, milk was given to residents for all three meals for three months. -Then she told staff to give milk to residents only at breakfast or when requested, because the resident would not drink the milk. Observation during breakfast on 9/16/15 at 8:15 a.m. revealed all of the residents were served 1 cup of milk. Interview with the Resident Care Coordinator on 9/16/15 at 10:10 a.m. revealed: -Milk was served at breakfast. -Since she had been working at the facility (October 2014), milk was served at lunch and dinner if the resident request milk. -The Cook tells dietary staff the beverages to pass out during the meals.	D 299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 299	Continued From page 35 Interview with the Resident Care Director on 9/16/15 at 10:15 a.m. revealed: -Since she had been working at the facility, she was unsure if milk was served for breakfast lunch or dinner. -The Administrator-in-Charge was responsible for dietary. -The Dietary Supervisor would be responsible for making sure the aides were aware to pass out milk during the meals. Interview with a fourth PCA on 9/16/15 at 10:23 a.m. revealed: -She had been working at the facility for the past two months. -She had only passed out milk to the residents at breakfast since she had been working at the facility. -She was just told on today (9/16/15) to start passing out milk during lunch to the residents. Interview with a fifth PCA on 9/16/15 at 10:34 a.m. who worked first and second shift revealed: -She had worked first shift for one month. She had just changed to second shift June 2015. -Milk was usually served to the residents at breakfast and at lunch if the resident requested milk. -Milk was not served or offered to residents at dinner. -The residents received milk at dinner upon request. Observation of the dinner meal on 9/16/15 at 5:35 p.m. revealed: -All 27 residents in the dining room were served 1 cup of milk during the meal. -Eight residents drank all of the milk.	D 299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 299	Continued From page 36 Interview with the Administrator-in-Charge on 9/17/15 at 9:00 a.m. revealed: -She had been working at the facility since February 2015. -She had served as the Administrator-in-Charge since August 2015. -Milk should be served to the residents twice daily. -She had not observed dietary meals while serving as the Administrator-in-Charge. -She was not aware milk had not been served twice daily to the residents. The Cook was not available for interview. Based on observation, interview and record review, the residents were not interviewable.	D 299		
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: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure medications (Novolin R insulin, Aricept, Protonix, Vitamin D, Senna S and Omeprazole) were administered as ordered for 3 of 4 residents	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 (Residents #15, 16, and 17) observed during the morning medication pass on 9/15/15. The finding are: A. Review of Resident #17's current FL-2 dated 4/7/15 revealed Diagnoses included Diabetes Mellitus II, chronic renal failure, diabetic peripheral neuropathy and vascular dementia. Review of the Resident Register revealed Resident #17 was admitted to the facility on 4/25/15. 1. The 4/7/15 FL-2 medication orders included: -Administration of regular insulin subcutaneously (sq) three times a day before meals ("meds list for details)" and "insulin - Novolin R (a short acting insulin used to control blood sugar) adjusted dosage subcutaneous (sq) before meals with parameters and dosage. -The "med list" identified the dosage of Novolin R insulin as 4 units three times daily before meals. -The parameters and dosage for the Sliding Scale Insulin (SSI) orders were: if Fingerstick Blood Sugar (FSBS) = 150-200, give 2 units; if FSBS = 201-250, give 4 units; if FSBS = 251-300, give 6 units; if FSBS = 301-350, give 8 units; if FSBS = 351-400, give 10 units; and if FSBS >400, give 14 units. Review of a subsequent physician orders dated 5/8/15 continued the Novolin R 4 units before each meal and the same SSI parameters and coverage dosages three times daily. Observation of the Medication Aide (MA) on 9/15/15 between 7:55 am and 8:15 am revealed: -The MA performed a FSBS with the FSBS results reported and documented as 211 and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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	D 358		

verified in the glucometer history.
-The MA reviewed the Medication Administration Record (MAR) for directions for the SSI parameters.
-The MA withdrew 4 units from a multi-dose vial of Novolin R insulin at 8:10 am and administered the medication into the resident's right deltoid.

Review of the pharmacy label for the multi-dose vial of Novolin R revealed instructions to administer 4 units before each meal and adjusted dose parameters based on FSBS before meal in addition to the 4 units.

Review of Resident #17's MARs for May 2015 through September 2015 revealed:
-The May 2015 MAR had an entry for Novolin R 4 units to be administered before meals scheduled at 6:00 am, 11:30 am and 4:30 pm with documentation of administration.
-The June 2015 MAR had an entry for Novolin R 4 units to be administered before meals scheduled at 6:00 am, 11:30 am and 4:30 pm with documentation of administration.
-The July 2015 MAR had a hand written entry for Novolin R 4 units to be administered before meals scheduled at 7:30 am, 11:30 am and 4:30 pm with documentation of administration from 7/1/15 through 7/21/15 with "d/c" written through the rest of the month.
-The August 2015 MAR did not have an entry for Novolin R 4 units to be administered before meals. The MAR contained only the SSI insulin parameters and dosage. The range of FSBSs was 114 to 422.
-The September 2015 MAR had an entry for Novolin 4 units before each meal with "D/C" hand-written beneath the entry. No documentation of administration was present. The range of FSBSs was 176 to 520.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 Interview with the MA on 9/15/15 at 12:00 pm revealed: -She had been employed since January 2015. -She remembered administering a base amount of insulin before meals for Resident #17 but not for several months. -The MA thought the base units of insulin had been discontinued but did not recall when. -She only administered Novolin R based on SSI parameters. Interview with the prescribing physician's office nurse on 9/15/15 at 3:50 pm revealed: -The nurse stated the resident's last office visit was 6/23/15. -The resident's HgA1C (a test for blood sugar control over a three month period) completed during the office visit was 7.1% (a goal for diabetics is for the HgA1C to be less than 7%). -The resident's previous HgA1C was in February 2015 and was 6.9%. -The doctor was not aware the resident did not receive the Novolin R 4 units before each meal and was only receiving SSI coverage for the last 2 months. -The doctor had not changed the insulin orders and had received no communication from the facility regarding any discontinuation of the Novolin R 4 units before each meal. Interview with the facility's pharmacy on 9/15/15 at 12:37 pm revealed: -The Novolin R 4 units before each meal was a current order in addition to the SSI parameters and dosage. -The pharmacy had not received an order to discontinue the Novolin R 4 units before each meal.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 Interview with a second shift MA at 4:30 pm on 9/15/15 revealed: -She had worked as a MA since July 2015. -She had not administered a base amount of insulin to Resident #17, only the SSI. -The FSBS for Resident #17 was 200 at 4:25 pm on 9/15/15 and she administered 2 units of insulin according to SSI parameters only. Interview with another first shift MA on 9/16/15 at 7:40 am revealed: -She only gave Resident #17 the SSI insulin coverage. -The MA reported she remembered the order for the 4 units of Novolin R before meals had been canceled sometime in mid-July 2015. -The Resident Care Director (RCD) was supposed to get a clarification. Interview with the RCD on 9/15/15 at 4:00 pm revealed: -She was not aware the order for the Novolin R 4 units before each meal had been "cancelled." -Upon review of the July 2015 MAR, the RCD could not recognize the writer of the "D/C" notation; she stated it was not her writing as she always initialed any notations on the MAR. -The RCD, the Resident Care Coordinator (RCC) and another MA would check the MARs month to month for accuracy, ensuring at least two staff reviewed the MARs each month. -The order for the 4 units of Novolin R must have been overlooked and not verified by the staff. Based on observation, record review and attempted interview with Resident #17, it was determined he was not interviewable. 2. Observation of the morning medication pass on 9/15/15 between 7:55 am and 8:15 am and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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	D 358		

interview at the same time revealed:
-The MA prepared and administered 10 oral medications to Resident #17 and documented the administration on the MAR.
- Senna S (to prevent constipation and soften bowel movements) and omeprazole 40 mg (for gastric reflux were not included in the 10 medications prepared and administered.

Interview with the MA on 9/15/15 between 7:55 am and 8:15 am revealed:
-Two medications, Senna S and omeprazole 40 mg were not given because they were not available.
-The MA had spoken with the resident's family 3 days ago to let him know they were out of the omeprazole.
-She had communicated to the family member 5 days ago that the facility was out of 2 additional medications, one of which was Senna S.
-She did not inform the RCD of the medication shortage.

a. Review of the Resident #17's current FL-2 dated 4/7/15 revealed an order for omeprazole 40mg daily.

Review of the September 2015 MAR revealed;
- There were 12 medications scheduled for administration at 7:30 to 8:00 am. daily
-Omeprazole was documented as administered from 9/1/15 to 9/15/15 at 7:30 am.

Continued interview with the MA on 9/15/15 at 8:15 revealed:
-She did not have any omeprazole to give this morning.
-She had notified the family on 9/12/15 the omeprazole was not available.
-She reported the resident had his medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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	D 358		

shipped directly to the facility from the VA pharmacy.
-The MA knew to call the family and request medications when there was only a weeks worth left.
-She did not notify or use the communication log to let any one else know there was no omeprazole to administer.
-She did not check to see if anyone else was receiving omeprazole that she could borrow.

Interview with the RCD on 9/15/15 at 4:00 pm revealed:
-She was not notified that some of Resident #17's medications were not available for administration.
-The facility had in the past requested one week's medication from the facility pharmacy when VA residents run out because of the 5 to 7 days it took to get medications delivered.
-The staff are supposed to use the communication log to let everyone know when medications were not available.

b. Review of the Resident #17's current FL-2 dated 4/7/15 revealed an order for Senna S two tablets daily.

Review of the September 2015 MAR revealed:
-Senexon-S (Senna S), 2 tablets twice daily was transcribed to the MAR and scheduled for administration at 8:00 am and 4:00 pm daily.
-Senna S was documented as administered 14 of 30 dose opportunities.
-Senna S was intermittently circled and documented on the reverse side of the MAR as not available or not given, beginning 9/3/15 and ending 9/15/15.
-In the documented response/results column of the reverse MAR was "awaiting pharmacy or pharmacy contacted."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 43 Interview with the MA on 9/15/15 at 8:15 am revealed: -She did not administer the Senna S because there was none available to administer. -She had spoken with the family on 9/10/15 about being out of the Senna S. -She stated the staff usually had to give the family a week's notice for the medications to arrive from the VA. -The MA did not know when the first contact was made with the family, but she had not had Senna S available for administration for several days. Interview with the RCD on 9/15/15 at 4:00 pm revealed: -She was not notified some of Resident #17's medications were not available for administration. -The facility had in the past requested one week's medication from the facility pharmacy when VA residents run out because of the 5 to 7 days it took to get medications delivered. -The staff are supposed to use the communication log to let everyone know when medications were not available. Interview with Resident #17's family on 9/16/15 at 10:19 am revealed: -Someone from the facility had call him last week (9/10/15) to let him know the resident was out of 2 medications. -The family member received a call on Saturday (9/12/15) regarding another medication which was also not available for administration. -The family member had asked staff to let him know 10 days before the medication ran out as the VA does take 5-7 days to send the medication. -No one suggested the family member could get the medication at the drug store over the counter	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 44 to last until the VA sent the medication. Based on observation, record review and attempted interview with Resident #17, it was determined he was not interviewable. B. Review of Resident #16's current FL-2 dated 5/8/15 revealed: -Diagnoses included dementia, atrial fibrillation, congestive heart failure and hypertension. -Medications ordered included Aricept 10 mg daily (used for treatment of dementia) and Protonix DR (used to treat gastric reflux and distress) 40mg daily. Observation of the medication pass on 9/15/15 between 7:40 am and 7:45 am revealed: -The MA prepared 9 medications for administration. -Six of the 9 medications were crushed and mixed with applesauce. -Two of the six crushed medications were Aricept 10 mg and Protonix 40 mg. Review of the September 2015 MAR revealed: -Entries for Aricept 10mg daily and Protonix 40 mg scheduled for administration at 8:00 am daily. -Included in the transcription entries were instructions "**DO NOT CRUSH**." -Documentation of administration at 8:00 am on 9/15/15. Interview with the MA on 9/15/15 at 12:00 noon revealed: -The MA crushed Resident #16's oral medications because, for the last month or so, the resident would "cheek or pocket" oral medications and not swallow them. -She thought everyone was crushing the resident's medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 45 -She was aware of the information on the MAR to not crush Protonix or Aricept but did not ask for clarification. -She did not call the pharmacy to obtain assistance for administration of the Protonix or Aricept. Interview with the facility's pharmacist on 9/15/15 at 12:37 pm revealed: -The Protonix should not be crushed because it would not be absorbed in the correct location and the medication might not be effective. -The Aricept should not be crushed because it had a more unpleasant taste and increased the potential for nausea. -The staff at the facility are instructed to follow the administration guidelines on the MAR before crushing. -The pharmacy included instruction of "Do not Crush" for all medications that should be given whole. Review of Resident # 16's record revealed: -Standing orders dated and signed by the physician on 2/4/15. -The orders included "May crush meds unless contraindicated." Interview with the RCD on 9/15/15 at 4:00 pm revealed: -All medication staff should know not to crush any medication the pharmacy had identified as "Do not Crush" on the MAR. -She was not aware staff had crushed Resident #16's Protonix and Aricept. Based on observation and record review, it was determined Resident #16 was not interviewable. C. Review of Resident #15's current FL-2 dated	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 46 1/23/15 revealed; -Diagnoses included Alzheimer's Dementia and Hyperlipidemia -Medication ordered included Vitamin D 2000 units daily (a dietary supplement to promote bone strength). Observation of the morning medication pass at 7:35 am on 9/15/15 revealed: -The MA prepared and administered 3 oral medications, which included Vitamin D 2000 units. -All medications were crushed and given with 1 teaspoon of applesauce. Review of the September 2015 MAR revealed: -An entry for Vitamin D 2000 units scheduled at 9:00 am daily -Documentation Vitamin D 2000 units was administered at 9:00 am daily from 9/1/15 through and including 9/15/15. -The resident's other medications were scheduled at 8:00 am. Interview with the MA on 9/15/15 at 12:00 noon revealed: -She usually gave all of Resident #15's morning medications around 7:30 am or so. -She was not aware the Vitamin D was scheduled at 9:00 am, instead of 8:00 am. -She did not know if other MAs gave Resident #15's Vitamin D at the scheduled time or not. -She stated she was taught to look at the schedule times of medications on the MAR before preparing for administration. Interview with the RCD on 9/15/15 at 4:00 pm revealed: -She was not aware the Vitamin D was scheduled at 9:00 am daily.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 47 -She was not aware the Vitamin D was given with the other medications scheduled at 8:00 am. -The medication schedule should have been changed so that all of the medications should be given at one time. -None of the MAs had reported to her the medications were not scheduled at the same time. -She was responsible for checking the MARs monthly for accuracy and had not noticed the medication scheduled times for Resident #15. Based on observation and record review, Resident #15 was determined not to be interviewable. _____ The facility provided the following Plan of Protection on 9/16/15: -All sliding scale orders were clarified and corrected on the MAR. -All medications missing were ordered and to be delivered on 9/16/15. -Retrain current MA on "Do not crush" list and place list in front of all MAR books. -Audit all diabetic MARs for appropriate SSI order and parameters -Implement Blood Glucose flowsheet for all diabetic residents. -Audit files to ensure pharmacy agreement in place for all residents. -Review all medication administration times and adjust accordingly for appropriate medication distribution. -All items will be completed within 48 hours. and the Executive Director will monitor. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED November 5, 2015.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 468	Continued From page 48	D 468		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interview and review of personnel records, the facility failed to assure 4 of 6	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 468	Continued From page 49	D 468		

sampled staff completed 6 hours of orientation on the nature and needs of the residents within the first week of employment and/or 20 hours of training specific to the population being served within 6 months of employment. (Staff B, C, D, E)

The findings are:

A. Review of Staff E's personnel records revealed:
-She was hired on 1/23/14 as a Medication Aide/ Nurse's Assistant (MA/ NA).
-She completed six hours of orientation on the nature and needs of the resident in the special care unit.
-There was no documentation in Staff E's personnel file that she completed the additional twenty hours of orientation on the nature and needs of the resident in the special care unit within six months of employment.

Staff E was not available for interview.

Interview with the Interim Executive Director (ED) on 9/21/15 at 3:25 P.M. revealed:
-She started working at facility on 2/23/15.
-Did not know why Staff E did not have her additional 20 hours of SCU training.
-The ED prior to her would have been responsible for making sure those 20 hours of SCU were completed.

B. Review of Staff B's, medication aide, personnel record revealed:
-She was hired as a medication aide on 8/3/15.
-A certificate dated 9/14/15 for 3 continuing education units in Alzheimer's General Lesson.
-A certificate dated 9/14/15 for 3 continuing education units in "Alzheimer's disease: The Beautiful Truth of Lying."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 468	Continued From page 50 Interview with Staff B, medication aide, on 9/16/15 at 3:15 revealed: -She has worked at the facility for about 2 months. -For training at the facility, she shadowed other staff for a couple of days then she went on the floor. -Some training modules had been available to complete on the computer. -She did not complete any orientation training on the computer. -She did not complete any training on the computer recently. -She was not aware of any training available to her on the computer. -She did not take any classes on Monday 9/14/15. -She had prior experience in a special care unit. C. Review of Staff C's personnel record revealed: -She was hired as a certified nursing assistant on 7/6/15. -A certificate dated 9/14/15 for 3 continuing education units in "Alzheimer's General Lesson." -A certificate dated 9/14/15 for 3 continuing education units in "Alzheimer's disease: The Beautiful Truth of Lying." Staff C was not available for interview. D. Review of Staff D's, medication aide, personnel record revealed: -She was hired as a medication aide on 9/13/13. -A certificate dated 9/13/13 for 3 continuing education units in Alzheimer's. -A certificate dated 9/13/13 for 3 continuing education units in "Alzheimer's disease: The Beautiful Truth of Lying."	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 468	Continued From page 51 -A certificate dated 9/10/14 for 1 continuing education unit in "Last Days and Hours." Interview with Staff D, medication aide, on 9/18/15 at 3:30pm revealed: -She has been working at the facility for 2 years. -Her orientation was not online; she met with a nurse from the facility pharmacy. -Now trainings are done on the computer and onsite for continuing education units. Interview with the Administrator on 9/16/15 at 12:30pm revealed: -There is a new hire checklist that is used currently. -Staff records are maintained by the Administrator-in-Charge/Interim Executive Director (IED) with support of the Resident Care Director. -Prior to the current IED, staff records were maintained by the Executive Director that was "let go" about 4 weeks ago. -The expectation is that staff records are completed correctly. Interview with the Administrator-in-Charge/Interim Executive Director, on 9/17/15 at 11am and 12:30pm revealed: -Each staff member is required to have 6 hours of special care unit training in the first week of employment and then 20 hours completed within 6 months. -The facility pharmacy provides the 6 hours of orientation and training online; after that classes are done at the facility by the pharmacy and other agencies. -To her knowledge, there have not been any onsite continuing education units at the facility since April 2015. -She started working at this facility in February	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 468	Continued From page 52 2015 as the business office manager. -Staff records were very unorganized at that time. -A new hire checklist for staff records was developed about the time she started in February 2015. -A revised new hire checklist was recently developed in June or July 2015 and that is what the facility is using currently. -As the Interim Executive Director, she is in the process of implementing an orientation process for new hires. -Staff monthly meetings are mandatory and soon training will be conducted during those meetings for staff. Interview with facility pharmacy on 9/17/15 at 1:20pm revealed: -Facility staff are able to take online classes for continuing education units and classes are taught at the facility for continuing education units. -The online classes are set up so staff can only get continuing education units for one class per day. -Typically the certificate has to be printed when you take the online class. -Unfortunately there was a "glitch" with the pharmacy software and facility staff was able to take more than 1 online class per day and receive continuing education units. -As a result of the glitch, there is no record of when facility staff actually took classes.	D 468		
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	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 53 regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed 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 Medication Administration and Health Care Personnel Registry verifications. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to assure medications (Novolin R insulin, Aricept, Protonix, Vitamin D, Senna S and Omeprazole) were administered as ordered for 3 of 4 residents (Residents #15, 16, and 17) observed during the morning medication pass on 9/15/15. [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).] 2. Based on interview and record review, the facility failed to assure 1 of 6 sampled staff had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hired. [Refer to Tag D 137, 10A NCAC 13F .0407 (a)(5) (Type B Violation).]	D912		
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:	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R 09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTEF	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 54 Based on observation, interview and record review, the facility failed to assure residents were free of neglect related to a resident receiving a leg laceration while receiving personal care and failure to implement orders for wound care. The findings are: 1. Based on observation, record review and interview, the facility failed to assure personal care was provided to 1 of 6 sampled residents who needed 2-person assistance and received a leg lacreation while staff provided personal care. (Resident #6). [Refer to Tag D 269, 10A NCAC 13F .0901(a). (Type A1 Violation)] 2. Based on record review and interview, the facility failed to assure the implementation of discharge orders from a hospital physician for 1 of 6 sampled residents who did not receive wound care as ordered for a leg laceration requiring staples (Resident #6). [Refer to Tag D 276, 10A NCAC 13F .0902(c)(3-4) (Type B Violation)].	D914		